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Evaluation of the Medicare-Approved Prescription Drug Discount Card and Transitional Assistance Program

Final Evaluation Report

May 5, 2006

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Executive Summary

Under a task order from the Centers for Medicare and Medicaid Services (CMS), Abt Associates Inc. is evaluating the impact of the Medicare-Approved Prescription Drug Discount Card and Transitional Assistance (T.A.) program for people with Medicare. This Final Evaluation Report synthesizes findings to identify lessons for the Medicare Prescription Drug Coverage (Part D) implementation.

This evaluation was part of a larger effort by CMS to collect information from all stakeholders (beneficiary and non-beneficiary) involved in the Medicare Prescription Drug Discount Card and T.A. program to determine the impact of the program and to derive some lessons for the implementation, design and operation of the Medicare Prescription Drug Coverage Program. CMS and Abt Associates have been involved in ongoing communications regarding the findings from this evaluation to provide input into the larger effort. Appendix A is a document created by CMS that further describes how lessons learned from operating the Medicare Prescription Drug Discount Card have been applied by CMS toward implementation of the Part D drug benefit.

The research questions addressed in the evaluation include:

- Whether and how beneficiaries heard about the Medicare-Approved Drug Discount Card and Transitional Assistance program;
- Whether card enrollees were aware of having a Medicare-Approved Drug Discount Card, and were aware that they had many cards from which to choose;
- How and why they enrolled and why some beneficiaries who heard about the program didn't enroll;
- Where they got information when choosing a card, what factors were important in deciding on a card, and why they chose the card they did;
- How much beneficiaries know about how the program is supposed to work;
- What early experiences card enrollees were having with the cards, whether they were satisfied with their cards and with savings, or have had problems using cards;
- Whether beneficiaries are aware that changes were coming (Part D);
- What were the trends in Medicare-Approved Drug Discount Card enrollment, for the program as a whole, for key beneficiary groups, for major card types, and across cards;
- How did enrollees differ among national, regional and exclusive programs;
- When and how frequently did enrollees switch drug cards, and how did enrollees who switched differ from enrollees who did not; and
- How can survey data be used to develop performance measures to monitor prescription drug plans under Part D.

Fifty-four focus groups with drug card enrollees and non-enrollees were conducted in the fall of 2004 (30 groups) and the winter of 2005 (24 groups). A survey of 32,434 Medicare beneficiaries enrolled in drug discount cards was conducted in the fall of 2004 and another survey of 32,400 in the spring of 2005. (See Appendices for focus group and survey methodologies.) An analysis of enrollment and

switching was undertaken using CMS administrative data. Finally, we assessed these data sources for purposes of performance monitoring.

Awareness

Almost all non-enrolled focus group participants had heard of the drug discount card program, most through a combination of media attention and CMS mailing(s). The widespread awareness of this new program was achieved in just a few months.

The majority of survey respondents reported that they had enough, or more than enough, information to make an enrollment decision. At the same time, 63 percent of the 2005 survey respondents did not consider more than one drug card, and many of these did not realize that there was more than one to choose from. Many focus group participants enrolled in the first card they heard about. The fact that many beneficiaries were so easily satisfied with limited information, and enrolled in the first card they heard about, indicates the challenge of educating beneficiaries about choices.

Forty-four percent of the 2005 survey respondents reported that they either did not have a drug discount card or did not know if they had a card, although all did (according to CMS administrative data). About a quarter of those with the T.A. credit (according to CMS administrative files) believed they did not have the $600 credit and others were unsure. There are many plausible explanations for this lack of awareness. One explanation may be that Medicare beneficiaries are inundated with unsought/unwanted insurance mailings and discard most of them unopened – some may have inadvertently discarded their new Medicare drug discount cards unopened. Some of those who were auto-enrolled by State Pharmacy Assistance Programs or had their enrollment facilitated by CMS[1] may have been unsure of their status because they did not fill out applications. And it is possible that some beneficiaries' insurance issues were handled by a family member, with the beneficiaries (survey respondents) being unaware of their insurance details.

Information Sources and Choice

Most focus group participants reviewed information that came to them rather than searching for information themselves. There was only modest evidence of active information-seeking among the hundreds of focus group participants.

The most frequently used source of information about drug discount cards was pharmacists, according to both survey respondents and focus group participants. Pharmacists played a key role in helping Medicare beneficiaries understand the program, enroll in drug cards, and use their drug cards. Other commonly mentioned sources of information were mass media (especially television), insurers and health plans with which beneficiaries already had relationships, and AARP and its publications.

Twenty percent of the 2005 survey respondents had called 1-800-MEDICARE for information and nine percent had used the Medicare website; only four percent mentioned any type of information counselor or service. Focus group participants were also asked about their use of the CMS information channels. About half of focus group participants recalled receiving mailing(s) from CMS about the drug discount card program. About a quarter of focus group participants had used the Medicare helpline to get information about the drug discount card program, and a smaller proportion of focus group participants got information from the Medicare website, either directly or with the help of a family member, friend or counselor who accessed the website for them. Almost no one in any of

[1] Throughout this report the term "auto-enrollment" is used to refer to group enrollment, facilitated enrollment, and automatic enrollment.

the focus groups had used (or recognized the name of) their local State Health Insurance Program (SHIP), and very few survey respondents indicated any "health insurance counseling service" as an information source.[2] At the same time, many focus group participants expressed a strong preference for receiving information one-on-one and in-person from someone with whom they could discuss their own personal circumstances. Thus although many beneficiaries seemed to want this sort of personalized counseling, they did not seem to know where to find it. CMS is therefore promoting SHIP resources and services as a feature of the 2005-2006 National Medicare Education Program (NMEP).

Reasons for Not Enrolling

Most non-enrolled focus group participants had heard about the drug discount card program, but many held misperceptions that kept them from enrolling, while others did not think they would benefit from enrollment. The most common misperception was that only persons with limited incomes could enroll in a Medicare-Approved Drug Discount Card. Apparently the eligibility for T.A. and the eligibility for the card itself were conflated in the minds of some beneficiaries. Some low-income beneficiaries who were not enrolled were under the mistaken impression that they would have to pay a monthly premium to obtain a drug discount card and the T.A. benefit; they did not know whether they would save enough to warrant the (mistaken) monthly premium. Under Part D there are monthly premiums for most enrollees, so this concern about monthly premiums may become more relevant.

There were a number of other reasons for not enrolling in drug discount cards. Several focus group participants reported that the prices they paid at discount retailers (Costco, Sam's Club) were lower without the card than with it. Others had few prescriptions to fill or felt that the senior discount offered by their local pharmacy was better than the discount offered by drug cards. Some focus group participants got information about cards but found the multiplicity of choices to be overwhelming. A few focus group participants knew that the program would be temporary and did not want to engage in a complicated choice process for a program that would last little more than one year.

Experiences with Drug Discount Cards

Enrollment

Focus group card enrollees reported no difficulties in enrolling in drug discount cards by phone, mail or over the Internet. A number of them did, however, report lengthy delays in receiving their drug discount cards in the mail (although some may not have recognized the mailings that contained their cards, and inadvertently discarded them).

Satisfaction

Most survey respondents expressed overall satisfaction with their cards. They were especially satisfied with the choice of pharmacies at which they could use their cards and with the enrollment process. Satisfaction with savings was a little lower. Those getting the T.A. credit were much more satisfied with savings than were those without the T.A. credit.

Survey respondents who had considered more than one discount drug card were only a little more likely to be satisfied with their card compared with those who had not considered more than one card.

[2] It is possible that beneficiaries were receiving help from these sources, by a counselor at a senior center or elsewhere, but did not consider this to be a "counseling service."

Apparently engaging in the choice process made only a small difference in respondents' satisfaction with the cards they chose.

Those taking more prescription medications were somewhat more satisfied overall and more satisfied with savings, than were those with fewer prescriptions.

Some drug discount cards had more satisfied enrollees overall than others, and some had more dissatisfied enrollees. These card-level differences in satisfaction extended to satisfaction with savings as well.

Savings

Fifty-six percent of 2005 survey respondents reported that they have saved "some" or "a lot" of money using their cards; those with T.A. were the most enthusiastic about savings, probably because most had not yet exhausted their $600 credit. However even those without T.A. reported saving money using their cards, indicating that the discounted prices available through cards are bringing tangible benefits. Overall, 49 percent were saving as much or more money than they had expected to save with their drug discount cards. With Medicare prescription drug coverage, potential benefits for those who are not low-income will be greater, and for those with limited-incomes, greater yet (especially if they were previously uninsured); as a result, perceived savings are likely to rise even more.

Beneficiary satisfaction with drug discount cards depended almost entirely on how satisfied they were with the amount of money they thought they were saving by using the cards. This single item explained 71 percent of the total variance in overall satisfaction.[3] Adding information about satisfaction with the choice of pharmacy and the enrollment process increased the explained variance by only three additional percentage points.[4]

Three-quarters of surveyed beneficiaries who had T.A. were satisfied with the amount of money they saved, compared with 40 percent of those who did not have T.A. Just over 30 percent of those without T.A. were dissatisfied with the savings they experienced.

Many focus group participants with T.A. wanted to be able to track their $600 credit, to anticipate when it would run out. Some pharmacists were able to relay balances, but others said that they could not provide this information (even though pharmacists could access this information, electronically or by telephone, from any drug card sponsor).

Prescription Filling Practices

Most survey respondents (especially those with T.A.) used their cards every time they filled prescriptions.

Nearly half of all survey respondents acknowledged that at some time in the past they had decided not to fill prescriptions due to cost concerns, and a somewhat smaller percentage had at times skipped doses or taken smaller doses to stretch their medications. Fewer people reported these practices after receiving their Medicare-Approved Drug Discount Cards, at least for the few months immediately

[3] We estimated a simple regression of overall satisfaction (b4a) as predicted by satisfaction with amount saved (b4d) in this regression, $R^2 = 0.7106$

[4] We added the two other satisfaction measures, concerning the enrollment process (b4b) and choice of pharmacies (b4c) to the regression of savings (b4d). This raised R^2 to 0.7398.

after they received their cards, especially among those with T.A. There is potential for enhancing appropriate use of prescription medications through reduced prices and subsidies, especially for lower income beneficiaries who do not currently have prescription drug coverage.

Card Level Comparisons

Card enrollees' awareness of being enrolled and of having the T.A. credit, card use, satisfaction, problems with cards and savings varied considerably across the cards sampled for the two surveys. For non-exclusive cards sampled for the 2005 survey, awareness of being enrolled ranged from 33 percent (the card with the poorest rating on this measure) to 77 percent (the card with the best rating on this measure). The portion of respondents indicating they were satisfied with the drug card ranged from 49 percent to 92 percent among the cards sampled for the 2005 survey. Large variations in satisfaction remained even when T.A. status was controlled for, although having the $600 credit was the strongest determinant of satisfaction.

Each of the surveys found that some cards performed consistently well or poorly across multiple survey topics.

Enrollment and Switching

Enrollment volume varied greatly among drug cards and among the major card types (National, Regional, Exclusive). Enrollment was highly concentrated, particularly for National and Regional cards; the largest National card accounted for 10 percent of all National card enrollment. The same may be true under Part D, with a small number of PDPs being responsible for a majority of enrollees.

Overall, Medicare drug card enrollees were somewhat more likely to be in the 75–84 year age group and to be non-white than were non-enrollees. Compared to non-enrollees, enrollees were more likely to live in urban areas, in the South and West, and in areas with relatively high poverty levels. T.A. enrollees were twice as likely to live in non-urban areas as non-T.A. enrollees. T.A. enrollees were also more likely to live in the South and in high poverty areas than non-T.A. enrollees.

Over 18 months, Medicare enrolled 6.6 million drug discount cardholders (about 15 percent of 44 million[5] eligible beneficiaries). Most stayed with their first card; fewer than four percent switched cards during this period. Some of this switching was due to switching Medicare Advantage plans, which by necessity also meant switching drug discount cards; the action was not a reflection on the drug discount portion of the benefit but rather a decision to change managed care plans. Part D is a very different program and switching may be prompted by factors not present in the drug discount card program, most notably Prescription Drug Plan (PDP) formularies.

Performance Monitoring

Nine survey items could be used to measure performance of the prescription drug plans under Part D. Answers to these nine survey items were found to be highly correlated with one another.

Three suggestions for future surveys that aim to monitor prescription drug card performance:

[5] Total Medicare beneficiaries continuously eligible for Medicare Parts A and B during the 18-month study period.

- Since actuarial methods offer a more objective and precise assessment of financial impact than do respondents' ratings, specific questions about detailed aspects of the program could best be used to measure non-monetary satisfaction;

- To isolate economic effects and compare similarly situated beneficiaries, the survey could collect information about situational (financial) and health covariates;

- Since amount saved drives satisfaction, adjust survey satisfaction measures to reflect percent of enrollees in each prescription drug plan who have the Limited Income Subsidy (LIS).

Implications for Part D

Awareness of upcoming changes in Medicare drug coverage for 2006 was high, but detailed understanding about the new prescription drug coverage program was quite low. The main information sources beneficiaries turned to in the past, and will probably continue to rely on are pharmacists, media (especially television), insurers/agents/plans they already have relationships with, and AARP and its publications.

It will be important that beneficiaries understand that Part D drug plans are not only for those with limited incomes, that enrollment is not automatic (except for those who are auto-enrolled), and that there are many plans to choose from which are not all alike.

Part D drug plans should be aware that Medicare beneficiaries receive myriad mailings from insurance companies, which are often discarded unopened. Prescription drug plans will need to find effective ways to communicate with their enrollees (including getting them their new drug plan cards or other proof of coverage) in a timely manner.

Most beneficiaries with T.A. felt that their savings were as great or greater than expected, and many of those without T.A. had similar perceptions. With greater benefits available under Part D drug coverage, perception of savings could improve even more.

As with the drug discount cards, prescription drug plan enrollees who in the past found it unaffordable to always take their drugs as prescribed, may be better able to take their drugs properly; this may be especially true for those with limited incomes.

Overall satisfaction with drug discount cards was high and satisfaction with pharmacy networks was especially high; if Part D drug plans can maintain these robust networks, high satisfaction with this aspect of the program should continue.

Many beneficiaries learned that they can at times get lower prices from certain retailers by not using their drug discount cards; they became attuned to seeking the lowest possible price. Under Part D, some beneficiaries may similarly find lower prices during coverage gaps by going outside their drug plan network; if so, they will need to understand how to report any out-of-plan expenses to their drug plans, so that these expenses can be counted toward their true out of pocket (TrOOP) costs.

Beneficiaries will want to be able to track their benefits and anticipate when coverage gaps will begin and end. Drug plans will be sending monthly notices to plan members who fill prescriptions, containing this benefit information. Since beneficiaries often turn to their pharmacists for this information, it will be helpful if pharmacists can also provide this information to beneficiaries, in addition to drug plans sending regular benefit explanations to their members.

An important aspect of both drug discount cards and Part D prescription drug plans is the substantial assistance offered to beneficiaries with very limited incomes. T.A. participation in the drug discount card was achieved through the combined efforts of outreach from various CMS partners, auto-enrollment programs coordinated by State Pharmacy Assistance Programs and facilitated enrollment initiatives implemented by CMS in October 2004 and February 2005. The same will likely be true for Part D, with much of the limited-income (and dual-eligible) beneficiary population being enrolled through auto-enrollment and/or facilitated-enrollment mechanisms.

1.0 Background and Methods[6]

Under a task order from the Centers for Medicare and Medicaid Services (CMS), Abt Associates Inc. is evaluating the impact of the Medicare-Approved prescription drug discount card and Transitional Assistance (T.A.) program for people with Medicare. This Final Report synthesizes focus group findings, survey findings and card enrollment data to identify lessons for the Medicare Prescription Drug Coverage (Part D) implementation.

This evaluation was part of a larger effort by CMS to collect information from all stakeholders (beneficiary and non-beneficiary) involved in the Medicare Prescription Drug Discount Card and T.A. Program to determine the impact of the program and to derive some lessons for the implementation, design and operation of the Medicare Prescription Drug Coverage Program. In addition to this evaluation of beneficiary impacts of the Medicare Prescription Drug Discount Card, Abt also evaluated the impact on four non-beneficiary stakeholder groups (card sponsors, pharmacies, manufacturers, and states). That evaluation examined the experiences of these individuals through interviews, case studies and focus groups. This report will note some similarities and differences between the two sets of findings but will not attempt a full comparison.

CMS and Abt Associates have been involved in ongoing communications regarding the findings from this evaluation to provide input into the larger effort of implementing the Medicare Prescription Drug Coverage Program. Appendix A is a document created by CMS that further describes how lessons learned from operating the Medicare Prescription Drug Discount Card have been applied by CMS toward implementation of the Part D drug benefit.

The research questions addressed in the evaluation include:

- Whether and how beneficiaries heard about the Medicare-Approved Drug Discount Card and T.A. Program;
- Whether card enrollees were aware of having a Medicare-Approved Drug Discount Card, and were aware that they had many cards from which to choose;
- How and why they enrolled and why some beneficiaries who heard about the program didn't enroll;
- Where they got information when choosing a card, what factors were important in deciding on a card, and why they chose the card they did;
- How much beneficiaries know about how the program is supposed to work;
- What experiences card enrollees were having with the cards, whether they were satisfied with their cards and with savings, or have had problems using cards;
- Whether beneficiaries are aware that changes are coming (Part D);
- What were the trends in Medicare-Approved Drug Discount Card enrollment, for the program as a whole, for key beneficiary groups, for major card types, and across cards;
- How uneven was enrollment across cards;

[6] See the Appendix for complete, detailed focus group and survey methodologies.

- How did enrollees differ among national, regional and exclusive programs;
- When and how frequently did enrollees switch drug cards, and how did enrollees who switched fifer from enrollees who did not; and
- How can survey data be used to develop performance measures to monitor prescription drug plans under Part D.

Fifty-four focus groups were held in 15 cities: 30 focus groups in eight cities during the fall of 2004 and 24 focus groups in seven cities during the winter of 2005. Cities were selected for geographic variety and to concentrate on places where card enrollment was highest. Participants were selected using CMS administrative and card enrollment data. The final number and types of groups were as follows:

Exhibit 1: Focus Group Participants in 15 Cities

Type of Participants	# Groups	# Participants
Drug Discount Card Enrollees without T.A.	16	151
Drug Discount Card Enrollees with T.A.	12	88
Non-Enrollees (not eligible for T.A.)	12	89
Non-Enrollees with limited incomes (T.A. eligible)	6	32
Card Enrollees Medicare eligible due to disability	4	37
Card Enrollees with T.A., eligible due to disability	4	38
TOTAL	**54**	**436**

Participants received $60 ($80 for those with disabilities) to cover travel and other costs. All focus groups were videotaped and audio-taped. (See Appendix C for full focus group methodology.)

Two surveys of Medicare-Approved Drug Discount Card enrollees were conducted in the fall of 2004 and the spring of 2005. The two surveys were very similar, with a few questions added, removed or amended in the 2005 survey based on lessons from the first survey. The target population for the surveys was all Medicare beneficiaries who were enrolled in a Medicare-Approved Drug Discount Card at least a few months before the survey was fielded to allow them time to receive and begin using their card. The 2004 survey was fielded in September–November 2004 and the 2005 survey was fielded in April–June 2005. The first survey therefore included beneficiaries who enrolled within the first six to eight weeks after the cards became available; these beneficiaries might be considered 'early adopters'.

The sample selection for each survey was done in two stages. For the first stage, a purposive sample of 27 drug discount cards was selected. The second stage required selection of an independent sample of 600 T.A. card enrollees and 600 non-T.A. enrollees, from each of the 27 drug discount cards, for a total sample of 32,400 enrollees per survey. The surveys, with an advance letter from CMS, were mailed in mid-September, 2004, and mid-April, 2005, followed one week later by a reminder postcard. Three additional rounds of mailings were sent to non-respondents and the field period lasted 12 weeks. A 76 percent response rate was achieved for the 2004 survey and a response rate of 69 percent was achieved for the 2005 survey. Responses were weighted to reflect the size and composition of each of the individual cards' enrolled populations, and adjusted for non-response. (See Appendix B for full survey methodology.)

Four exclusive cards were included in the second survey to determine whether responses differed from those of persons enrolled in non-exclusive cards. Responses were indeed different, especially in that a high percentage of those in exclusive cards were unaware of their card enrollment (i.e., did not understand that their Medicare advantage plan had enrolled them in an exclusive drug discount card) (Exhibit 2). Seventy-two percent of exclusive card respondents indicated that they did not have a Medicare-Approved Drug Discount Card. Since the majority of exclusive card respondents were

unaware of enrollment, these cards' enrollees are *excluded from further analyses of survey data* in this report.

Exhibit 2: Awareness of Card Enrollment, Non-Exclusive Cards versus Exclusive Cards, Spring 2005 Survey

Do you have a card with this logo on the front of it (Medicare-approved Rx logo)?	All Respondents n=22,319	Non-Exclusive Cards			Exclusive Cards		
		Total n=19,154	T.A. n=10,487***	Non-T.A. n=8,667	Total n=3,165	T.A. n=1,728***	Non-T.A. n=1,437
Yes	55%	63%	83%	52%	22%	49%	20%
Yes, but waiting for card	1%	1%	1%	1%	1%	3%	1%
No	40%	31%	13%	42%	72%	42%	74%
Do Not Know	4%	4%	3%	5%	5%	6%	5%

Sources: 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.
* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01

Findings from each of the surveys were first analyzed to determine enrollee experiences with various card features, both at the aggregate level and by T.A. enrollment status. These results are presented in the Findings section. Next, the results for select questions were examined at the card-level to determine if differences existed between cards.

In addition to focus group and survey findings, we conducted a thorough analysis of enrollment and switching. Finally, we considered all of the information explored for this evaluation, and which items could potentially serve as performance measures for future Part D prescription drug plans.

2.0 Survey and Focus Group Findings

This Chapter of the report reviews the major findings of the evaluation, synthesizing focus group and survey results, and points out both strong themes and any inconsistencies. Differences between T.A. and non-T.A. respondents were analyzed for statistical significance and only statistically significant differences between these two groups of respondents are discussed in the text.[7] Chi-square tests were used to determine statistically significant differences between these two groups. All statistics presented here have been weighted to adjust for non-response and to reflect the populations of the cards from which respondents were sampled. Also, all findings concerning non-enrollees are from focus groups because the survey was only sent to beneficiaries who were enrolled in a Medicare-approved discount card.

2.1 Awareness

2.1.1 Awareness of the Drug Card Program and T.A.

In addition to most enrolled focus group participants and survey respondents, almost all non-enrolled focus group participants had heard of the drug discount card program, most through a combination of media attention and CMS mailing(s). The high level of awareness of this new program was achieved in just a few months.[8] Awareness of the T.A. subsidy was also very high overall, but slightly lower than awareness of the drug discount card program itself. Some focus group participants who were not enrolled and had limited incomes, would probably have qualified for T.A. but were unaware of the availability of the $600 credit.

2.1.2 Reasons for Not Enrolling

Most non-enrolled focus group participants had heard about the drug discount card program; the information they received/reviewed led them to decide against enrolling in a drug discount card. Many were misinformed or held mistaken impressions about drug discount card program features, and these misperceptions kept them from enrolling. The most common misperception was that only persons with limited incomes could enroll in a Medicare-Approved Drug Discount Card. Apparently the eligibility for T.A. and the eligibility for the card itself were conflated in the minds of some beneficiaries. Once convinced that their incomes were too high to qualify, these people stopped paying attention to additional information about the program.

There were also misperceptions about the cost of obtaining a card in order to receive the T.A. credit. Some focus group participants with limited incomes, who were not enrolled, were under the mistaken impression that they would have to pay a monthly premium to obtain a card and the T.A. benefit. For those with low or unpredictable prescription costs, a monthly premium was not acceptable.

Some beneficiaries who knew they did not qualify for T.A. saw little benefit in enrolling in a card. Several focus group participants reported that the prices they paid at discount retailers (Costco, Sam's Club) were lower without the card than with it. Some focus group participants who paid an annual enrollment fee for their cards were unhappy that prices with their cards were no better than through

[7] There were both regional and national cards in the sample but they were not selected to reflect the entire set of regional and national cards. Comparisons of regional vs. national findings are not included here because the sample of regional cards was too small to support reliable comparisons.

[8] The visibility of the program during the 2004 political season may have contributed to the very rapid learning about the program.

other sources and felt that they had purchased a card with little value and which they do not use. Others had few prescriptions to fill and felt that the senior discount offered by their local pharmacy was better than the discount offered by drug cards.

Some focus group participants got information about cards, but found the multiplicity of choices to be overwhelming; they learned enough to be confused and more or less gave up. Finally, a few focus group participants knew that the program would be temporary and did not want to engage in the complicated choice process for a program that would last little more than one year.[9]

2.1.3 Awareness of Being Enrolled

During the process of recruiting focus groups, we spoke with thousands of people listed in CMS files as being enrolled in Medicare-Approved Drug Discount Cards. Many told us that they were not aware that they had a Medicare-Approved Drug Discount Card. This was true in recruiting the 2004 focus groups and persisted in 2005, when nearly half of the enrollees we tried to recruit stated that they did not have a Medicare-Approved Drug Discount Card. It is possible that some were confused by our question or were simply trying to end the recruiting call, but many truly seemed to be unaware that they were enrolled.

This issue was quantified by the surveys, where the first question was "Do you have a card with this logo on the front of it?" followed by a display of the standard *Medicare Approved Rx* card logo. All survey respondents had enrolled (or been auto-enrolled) at least two months prior to being surveyed – most three to four months prior – and thus most should have received their cards[10] and been able to check their cards for this logo. However, many survey respondents were not aware they had a card. Twenty-three percent of respondents to the 2004 survey and 35 percent of respondents to the 2005 survey indicated that they either did not have a drug discount card or did not know if they had a card (Exhibit 3). In each of the surveys, this problem was more evident among those without T.A. than among those with T.A.

It is possible that some of the survey respondents who were unaware of their card enrollment had been auto-enrolled, rather than taking action on their own to enroll in a card.[11]

[9] Abt's Stakeholder Analysis cited a number of reasons for low enrollment, including a negative political climate, a negative assessment of value, and complex program design (too many choices, lock-in features, etc).

[10] Some focus group participants reported delays in receiving their cards. Lengthy delays were mentioned more by 2004 focus group participants than by those attending in 2005.

[11] CMS administrative data do not indicate which beneficiaries were auto-enrolled and which enrolled on their own.

Exhibit 3: Awareness of Enrollment in Medicare-Approved Drug Discount Card

	2004 Survey			2005 Survey		
Do you have a card with this logo on the front?	**All Respondents Non-Exclusive Cards**	**T.A.**	**Non-T.A.**	**All Respondents Non-exclusive cards**	**T.A.**	**Non-T.A**
	n=24,639	**n=12,457*** **	**n=12,182**	**n=19,154**	**n=10,487*** **	**n=8,667**
Have Card with Medicare Logo	77%	86%	72%	63%	83%	52%
Yes, but waiting for card	*NA*	*NA*	*NA*	1%	1%	1%
Do Not Have Card with Medicare Logo	21%	12%	26%	31%	13%	42%
Do Not Know if Have Card with Medicare Logo	2%	2%	2%	4%	3%	5%

Sources: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Fall 2004; 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.
* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01
NA: Question was not asked on both the 2004 and the 2005 surveys.

Focus group participants in 2004 who appeared to have been auto-enrolled were more likely to be unaware of their enrollment status than were 2005 focus group participants; perhaps because they had had only a few weeks or months to use their cards by the time the 2004 focus groups were held. For example, some focus group participants were auto-enrolled by their State Pharmacy Assistance Program (SPAP) and did not notice the tiny Medicare Rx logo on the front of their regular cards until they arrived at the focus groups and moderators pointed out the new logo. Similarly, some focus group participants were enrolled into exclusive cards by their Medicare Advantage Plans and hadn't noticed the new logo on the front of their insurance cards. Apparently the informational materials that reached auto-enrolled people were not always noticed, read, or well-understood.

Some people may not have realized that a mailing they received was in fact their new Medicare-Approved Drug Discount Card, and may have discarded it. Many focus group participants explained that they are inundated by sales materials from insurance companies; many no longer opened such materials and routinely discarded them. Some people filled out card enrollment forms for a card whose sponsor was unfamiliar to them; when the card arrived weeks later in the mail they did open the mailing but did not recognize the name of the sponsor on the envelope (often an insurance company) and discarded the card – not realizing what it was.[12] It is also possible that some people were uncertain of their enrollment status because their prescriptions (and their cards) were being

[12] Participants told us, however, that they were less likely to throw away mailings from a known and trusted source such as the Social Security Administration, AARP or their insurance carriers. When beneficiaries do eventually become familiar with their Part D drug plans, they may be more likely to open mailings from their plans.

handled by a family member. And it is possible that some beneficiaries' insurance issues were handled by a family member, with the beneficiaries (survey respondents) being unaware of their insurance details. All of these factors probably contributed to some beneficiaries, both focus group participants and surveyed card enrollees, being unaware of their enrollment status.

2.1.4 Awareness of Having T.A.

Survey respondents were asked whether they had received the $600 T.A. credit. Of those who were listed in the CMS administrative files as having the T.A. credit, thirty percent of 2004 survey respondents and 22 percent of 2005 survey respondents either said they did not receive the credit or were unsure if they had received the credit (Exhibit 4).

Exhibit 4: Awareness of Having $600 Credit

	2004 Survey			2005 Survey		
Whether or not you applied, did you get this $600 credit from Medicare?	**All Respondents Non-exclusive cards**	**T.A.**	**Non-T.A.**	**All Respondents Non-exclusive cards**	**T.A.**	**Non-T.A**
	n=21,002	**n=10,976*** **	**n=10,026**	**n=12,870**	**n=8,409*** **	**n=4,461**
Received $600 credit	29%	64%	6%	38%	73%	5%
Did Not Receive $600 credit	49%	13%	73%	42%	8%	73%
Do Not Know	12%	17%	9%	13%	14%	11%
Did Not Answer	10%	6%	13%	8%	6%	10%

Sources: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Fall 2004; 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.
* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01

The same factors that contributed to lack of awareness of enrollment (i.e., auto-enrollment, family members handling prescriptions, discarding mailings, not noticing the card logo) probably also contributed to uncertainty about T.A. status. Some of those with T.A. (as identified by CMS files) who indicated they did not have the $600 credit, may not yet have had a prescription to fill; they might become aware of the benefit when filling their first prescription using their Medicare-Approved Drug Discount Card.

Some of those who were auto-enrolled into a card by another program (a SPAP or a Medicare Advantage Plan) could use their familiar prescription cards and obtain discounts when pharmacists filled their prescriptions, without realizing it. Even those who were using the $600 credit may not have been aware that the credit was being accessed, if they were also in an SPAP or Medicare Advantage Plan. Thus some people who were unaware of being enrolled or unaware that they had T.A., may in fact have been getting some benefit from their Medicare-approved drug discount plans, without knowing that it was happening.

2.2 Information and Choices

The Medicare-Approved Drug Discount Card program, and the upcoming Part D Medicare drug coverage program, feature an annual choice among many competing options offered by private sector firms. A private sector market in Medicare Prescription Drug Plans under Part D would seem to require that a) Medicare beneficiaries are aware that they have choices, b) they are able to obtain and understand information about differences among plans so that they can make an appropriate choice, and c) they exercise their choice and select plans which they perceive as having better value. The next several sections explore these issues, in the context of the drug discount card program.

2.2.1 Applying for Cards

Respondents were asked whether they had applied for their Medicare-Approved Drug Discount Card or whether they had received their card without taking any action (being auto-enrolled by an SPAP or a Medicare Advantage plan). Eighty-five percent of all respondents who knew they had a drug discount card had applied for it; 10 percent reported they did not apply for the card they received; three percent did not know how they received their card; and two percent did not answer (Exhibit 5). T.A. respondents were more likely than Non-T.A. respondents to have applied for their card.

Exhibit 5: Applying for Cards, 2005 Survey Only

Did you apply for this card or did it come to you without any action on your part? For example, it just arrived in the mail, perhaps from a state program, an insurance company, or your HMO or managed care plan.	2005 Survey		
	All Respondents Non-exclusive cards n=13,192	T.A. n=8,601***	Non-T.A. n=4,591
Applied for this card	85%	87%	83%
Did not apply, came without any action	10%	8%	11%
Do Not Know	3%	3%	4%
Not Answered	2%	2%	3%
Total	100%	100%	100%

Source: 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.
Note: Respondents could check more than one category. Therefore, tests of significant differences between T.A. and Non-T.A. card enrollees are at the category level (rows) and totals do not sum to 100%.
.* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01

In the 2004 survey, all respondents who were aware they had a drug discount card were asked to answer questions regarding information sources and enrollment decisions. For the 2005 survey, only those respondents who indicated that they had applied for the card were asked to answer these questions. Some of the differences in responses regarding information and choices between the two surveys could be attributed to this difference in respondent groups.

2.2.2 Awareness of Choices

The 2005 survey gathered information about whether respondents were aware that there were multiple Medicare-Approved Drug Discount Card that they could choose among (this question was not on the 2004 survey). Fifty-nine percent of all non-exclusive respondents reported they were aware they had a choice of drug discount cards; 34 percent said they did not realize they had a choice before receiving the survey; six percent said they did not know; and one percent did not answer this question (Exhibit 6). Respondents with T.A. were less likely than those without T.A. to be aware that they had a choice among Medicare-Approved Drug Discount Cards.

Exhibit 6: Awareness of Choice of Cards, 2005 Survey Only

Before you got this survey, were you aware that there is more than one Medicare-Approved Drug Discount Card that you could apply for?	2005 Survey		
	All Respondents Non-exclusive cards n=10,935	T.A. n=7,129***	Non-T.A. n=3,806
Yes	59%	52%	64%
No	34%	40%	29%
Do Not Know	6%	7%	6%
Not Answered	1%	1%	1%
Total	100%	100%	100%

Source: 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.
Note: Respondents could check more than one category. Therefore, tests of significant differences between T.A. and Non-T.A. card enrollees are at the category level (rows) and totals do not sum to 100%.
.* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01

2.2.3 Comparing Drug Cards

Survey respondents were asked in two different ways about whether they considered more than one Medicare-Approved Drug Discount Card. Survey respondents were asked whether they considered and compared more than one card before making a choice; 63 percent of respondents to each of the surveys said they did not consider more than one card (Exhibit 7). Survey respondents were also asked why they enrolled in their particular card and respondents could check more than one reason. Forty-three percent of respondents to the 2004 survey and 35 percent of respondents to the 2005 survey said that theirs was the only card they looked into or considered (Exhibit 8, next section).

Results from both surveys indicate that respondents without T.A. were more likely than those with T.A. to consider more than one drug card. This is consistent with the finding (above) that those without T.A. were more aware of the multiplicity of available cards.

Exhibit 7: Comparing Multiple Medicare-Approved Drug Discount Cards

	2004 Survey			2005 Survey		
Did you consider and compare more than one Medicare-Approved Drug Discount Card before settling on the one you have now?	**All Respondents Non-exclusive cards**	**T.A.**	**Non-T.A.**	**All Respondents Non-exclusive cards**	**T.A.**	**Non-T.A**
	n=21,002	**n=10,976*** **	**n=10,026**	**n=10,935**	**n=7,129*** **	**n=3,806**
Yes	27%	25%	28%	31%	27%	35%
No	63%	64%	62%	63%	66%	59%
Do Not Know	4%	5%	4%	3%	4%	3%
Did Not Answer	6%	6%	6%	3%	3%	3%

Sources: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Fall 2004; 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.
* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01

Depending on the focus group, one-quarter to one-half of participants were unaware that there was more than one Medicare-Approved Drug Discount Card; nearly half of those who had not enrolled did not realize that there were choices. Based on these strong and consistent findings, it appears that many people were either unaware of choices, or did not engage in a choice process but simply enrolled in the first card they encountered. A key feature of the program – choice – which is supposed to move the market toward value, may not have had an optimal effect.

2.2.4 Comparing Choices

Survey respondents mentioned many reasons for enrolling in their particular card, in addition to the fact that many did not consider any others. The most common reason that survey respondents mentioned was that the card they chose was accepted by their pharmacies (73 percent to the 2004 survey and 77 percent to the 2005 survey) (Exhibit 8). Twenty percent of respondents to the 2004 survey and 28 percent of respondents to the 2005 survey reported that their pharmacist recommended the card they enrolled in. T.A. respondents were more likely to cite each of these top reasons. Many focus group participants said that they asked their pharmacist about the program (or the pharmacist offered information) and they signed up for the card their pharmacist recommended. These findings are consistent with the important role pharmacists play in providing information about the program (discussed in next section).

Costs were also important to survey respondents. An acceptable enrollment fee was among the top selection factors for respondents to both surveys, with approximately one third of respondents indicating that the annual enrollment fee influenced their drug card choice. Respondents without T.A. were more likely than those with T.A. to base their decision on the enrollment fee. Some focus group participants agreed, saying that they signed up for a free card (no annual fee) figuring that they had nothing to lose.[13]

[13] Pharmacists interviewed for Abt's Stakeholder Analysis also indicated that the acceptance of the card by their pharmacy and an acceptable cost/application fee were top choice factors for beneficiaries choosing cards.

Exhibit 8: Reasons for Choosing Medicare-Approved Drug Discount Card Have Now

	2004 Survey			2005 Survey		
Question A2: Please Check all of the reasons that you Chose the Medicare-Approved Drug Discount Card	**All Respondent Non-exclusive cards**	**T.A.**	**Non-T.A.**	**All Respondents Non-exclusive cards**	**T.A.**	**Non-T.A**
	n=21,002	**n=10,976**	**n=10,026**	**n=10,935**	**n=7,129**	**n=3,806**
Pharmacies I Use Will Accept My Card	73%	78%***	70%	77%	80%***	74%
Only Card I Looked Into or Considered	43%	41%***	45%	35%	37%***	33%
Pay Less With This Card Than With Other Drug Cards	31%	40%***	24%	*NA*	*NA*	*NA*
Annual Enrollment Fee for Card Was Acceptable To Me	34%	28%***	38%	35%	28%***	41%
Discounts on drug bought	*NA*[14]	*NA*	*NA*	56%	61%***	51%
Lower costs & helps pay for drugs	*NA*	*NA*	*NA*	64%	76%***	52%
My Pharmacist Recommended This Card	20%	23%***	19%	28%	30%***	25%
A Doctor or Other Medical Person Recommended This Card	6%	8%***	5%	7%	9%***	5%
A Friend or Family Member Recommended This Card	12%	15%***	9%	14%	18%***	9%
A Medicare Counselor or Information Service Recommended	11%	16%***	8%	11%	14%***	8%
A Health Insurance Agent or Company Recommended	10%	5%*	13%	5%	3%***	7%
Other Reason	4%	6%***	4%	9%	8%***	10%
Did Not Answer	4%	4%	4%	2%	1%***	2%

Sources: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Fall 2004; 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.
Note: Respondents could check more than one category. Therefore, tests of significant differences between T.A. and Non-T.A. card enrollees are at the category level (rows) and totals do not sum to 100%.
* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01
NA: Question was not asked on both the 2004 and the 2005 surveys.

[14] This and some other survey questions discussed in the tables in this report did not appear in both surveys. See the methodology for a discussion of the survey changes between the two administrations.

2.2.5 Common Information Sources

Most focus group participants reviewed information that came to them, rather than seeking it themselves.

Survey respondents, all of whom were enrolled in Medicare-Approved Drug Discount Cards, were asked to indicate all of the sources of information they used when deciding about a Medicare-Approved Drug Discount Card. According to results from both surveys, the most frequently used source of information was pharmacists (30 percent of 2004 survey respondents and 38 percent of 2005 survey respondents mentioned pharmacists as an information source; Exhibit 9).[15]

Focus group participants were also asked about information sources; pharmacies and pharmacists were mentioned in more focus groups than any other information source. Medicare beneficiaries felt comfortable asking pharmacists about the program, and often pharmacists offered information without being asked. Pharmacists played a key role in helping beneficiaries Medicare understand the program, enroll in drug cards, and use their drug cards.

It is not clear whether people who relied on pharmacists for enrollment information understood that some pharmacists work for companies that sponsored their own Medicare-Approved Drug Discount Cards, making these pharmacists a potentially biased source of information. For example, a national pharmacy chain sponsored a Medicare-Approved Drug Discount Card and many focus group participants reported that their pharmacists at the chain's outlets simply gave them the application for that chain's card, but did not explain that there were many card choices (all of which would be accepted by this chain).

Mass media was a common source of information for respondents to each of the surveys, with respondents to the 2004 survey citing television and radio as often as pharmacists. The Medicare help-line (1-800-Medicare) was not listed as an information source on the 2004 survey, but was ranked as the third most common source of information by respondents to the 2005 survey (after pharmacists and mass media). Friends and families were also often cited as a source of information by each surveys' respondents. T.A. respondents to each of the surveys were more likely than those without T.A. to get information from family and friends or a government agency, and less likely to get information from an insurance company or counselor (perhaps because they were less likely to have private insurance).

[15] Abt's Stakeholder Analysis found that most pharmacists reported making brochures and pamphlets available to beneficiaries. Most pharmacists reported, however, that counseling beneficiaries on drug card choices was beyond their expertise and few pharmacists reported having actually helped beneficiaries choose among the different drug discount cards.

Exhibit 9: Sources of Information

Please check all the places where you got information when you were deciding about your Medicare-Approved Drug Discount Card.	2004 Survey			2005 Survey		
	All Respondents Non-exclusive cards	T.A.	Non-T.A.	All Respondents Non-exclusive cards	T.A.	Non-T.A
	n=21,002	n=10,976	n=10,026	n=10,935	n=7,129	n=3,806
Newspapers or Magazines	15%	15%***	16%	*NA*	*NA*	*NA*
Television or Radio	30%	28%***	31%	*NA*	*NA*	*NA*
Media	*NA*	*NA*	*NA*	24%	25%***	23%
Family or Friends	14%	18%***	12%	15%	19%***	12%
Doctor or Other Medical Person	7%	9%***	5%	6%	7%***	5%
Pharmacist or Pharmacy	30%	34%	28%	38%	39%***	37%
Website Showing Price Comparisons	9%	8%***	10%	*NA*	*NA*	*NA*
Website (e.g., www.Medicare.gov)	*NA*	*NA*	*NA*	9%	6%***	12%
Other Internet Websites	2%	3%*	2%	*NA*	*NA*	*NA*
Health Insurance Company or Agent	13%	5%***	18%	5%	3%***	6%
Health Insurance Counselor or Information Service	4%	3%***	4%	3%	3%***	4%
AARP	10%	11%***	9%	NA	NA	NA
Employer or Former Employer	0%	0%	0%	0%	0%***	0%
Drug Manufacturer	*NA*	*NA*	*NA*	6%	6%***	7%
1-800-Medicare	*NA*	*NA*	*NA*	20%	24%***	16%
State / County / City Agency	6%	11%***	2%	5%	7%***	3%
Other Source of Information	14%	17%	12%	6%	6%***	7%
Got No Information When Choosing Card	8%	8%**	8%	4%	3%***	5%
Did Not Answer	4%	4%	4%	3%	3%***	3%

Sources: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Fall 2004; 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.

Note: Respondents could check more than one category. Therefore, tests of significant differences between T.A. and Non-T.A. card enrollees are at the category level (rows) and totals do not sum to 100%

.* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01

NA: Question was not asked on both the 2004 and the 2005 surveys.

2.2.6 Use of CMS Information Channels

Focus group participants were asked specifically about their use of the CMS information channels. About 50 percent of focus group participants recalled receiving mailing(s) from CMS about the drug discount card program. Some seemed to recall the separate CMS mailing about the program while others recalled mention of the program in the Medicare Handbook. Among those who recalled getting a CMS mailing, but who did not enroll in a card, most commented that the material they received from CMS was either difficult to understand or not sufficiently detailed. Some also reported that they don't actually read through these mailings when they arrive, but rather "file" them for later reference.

About 27 percent of focus group participants reported that they had used the Medicare helpline to get information about the drug discount card program. Some sought help to identify an appropriate card, while others wanted more general information about the program. These helpline users generally reported that the Customer Service Representatives were helpful and that they received the information they were looking for. Most of those who used the helpline did enroll in a Medicare-Approved Drug Discount Card. Almost none of the focus group participants who had not enrolled in a card had called the Medicare helpline for information.

About 13 percent of focus group participants mentioned getting information from the Medicare website, either directly or with the help of a family member, friend or counselor who accessed the website for them. (A majority of focus group participants reported that they did not have Internet access.) Use of the website was highest, proportionately, among people eligible for Medicare due to disability, who were younger than others with Medicare and may therefore be more comfortable with Internet/computer use in general. Many of those who did access the website were enthusiastic about it and found the information they needed, while a few found the website confusing due to the large number of card options listed. Those who did not have printer access found the website less useful because they could not print out the several pages of card options the website generated for them. Nine percent of survey respondents reported that they had used a website showing price comparisons, and another two percent had used other Internet websites in researching the drug card program. This total of 11 percent is very close to the estimated 13 percent of focus group participants who used the Medicare website.[16]

We asked focus group participants whether they had contacted their local SHIP organization – we used the local name of that organization since people may not have been familiar with the SHIP acronym. Almost no one in any of the focus groups had received information from this source, and the great majority had never heard of their local SHIP. Survey respondents were asked whether they got information from any "health insurance counselor or information service" which is a broader category than just the SHIPs, and less than four percent indicated this was among their information sources. At the same time, many focus group participants expressed a strong preference for receiving information one-on-one and in-person from someone with whom they could discuss their own personal circumstances. Thus although many people with Medicare want this sort of individualized counseling, they do not seem to know where to find it and are not receiving it.

[16] Abt's Stakeholder Analysis generally reported negative reactions to the CMS website, which was perceived as too confusing, as well as inaccessible to the Medicare population. Some Stakeholders did feel, however, that the website was a good resource for individuals (family members, counselors, etc) helping the Medicare population.

2.2.7 Adequacy of Information

Survey respondents were asked whether they had enough information at the time they enrolled in a drug card to make the necessary decision. Over half of the respondents to each of the surveys responded that they had enough, or more than enough, information to make this decision (Exhibit 10). At the same time, well over half the survey respondents to each of the surveys did not consider more than one drug card (or did not know there was more than one to choose from) (Exhibit 7, above). Many focus group respondents clarified that they enrolled in the first card they heard about. The fact that people were so easily satisfied with information about only one card, and enrolled in the first card they heard about, indicates the challenge of educating beneficiaries about drug discount card/plan choices.

Exhibit 10: Adequacy of Information to Made Card Enrollment Decision

	2004 Survey			2005 Survey		
When you signed up for your Medicare-Approved Drug Discount Card, do you feel you had all the information you needed to make a decision?	**All Respondents Non-exclusive cards**	**T.A.**	**Non-T.A.**	**All Respondents Non-exclusive cards**	**T.A.**	**Non-T.A**
	n=21,002	**n=10,976*** **	**n=10,026**	**n=10,935**	**n=7,129*** **	**n=3,806**
Had More Than Enough Info	15%	21%	11%	16%	21%	11%
Had About the Right Amount	39%	43%	37%	43%	47%	39%
Wanted More Information	23%	16%	28%	24%	16%	31%
Do Not Know	16%	14%	18%	14%	12%	16%
Did Not Answer	7%	6%	7%	3%	3%	3%

Sources: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Fall 2004; 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.
* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01

2.3 Experiences with Medicare Drug Discount Cards

2.3.1 Enrollment

Focus group participants, both those with T.A. and those without, reported no difficulty with the enrollment process for their drug discount cards. Whether they enrolled via a paper form, by telephone, or online, or got help from someone else to enroll, all agreed that the process was straightforward and clear.

Some focus group participants, particularly in 2004, reported that although enrollment was smooth they did not receive their cards in a timely manner. Some made many calls, and waited many weeks, before getting their cards in the mail.

2.3.2 Using Cards

Survey respondents were asked how often they used their Medicare-Approved Drug Discount Cards when filling prescriptions. Seventeen percent of respondents to the 2004 survey and 10 percent of the respondents to the 2005 survey had never used their cards. Sixty-five percent of respondents to the 2004 survey and 69 percent of respondents to the 2005 survey used their card every time they filled a prescription (Exhibit 11).

Exhibit 11: Use of Drug Discount Card

	2004 Survey			2005 Survey		
When you fill prescriptions, how often do you use your Medicare-Approved Drug Discount Card (like the one shown below – show logo)?	**All Respondents Non-exclusive cards**	**T.A.**	**Non-T.A.**	**All Respondents Non-exclusive cards**	**T.A.**	**Non-T.A**
	n=21,002	**n=10,976*** **	**n=10,026**	**n=12,870**	**n=8,409*** **	**n=4,461**
Every Time	65%	75%	59%	69%	78%	60%
Most of the Time	5%	6%	5%	6%	6%	6%
Some of the Time	4%	3%	5%	3%	3%	4%
Rarely Use the Card	4%	2%	5%	3%	2%	5%
Never Used	17%	9%	22%	10%	5%	15%
Do Not Know	1%	1%	2%	2%	1%	2%
Did Not Answer	3%	4%	3%	6%	6%	7%

Sources: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Fall 2004; 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.
* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01

At the time of the survey, most respondents with T.A. probably had not yet exhausted their $600 credit, and three fourths of respondents with T.A. reported always using their card. Among those T.A. recipients who reported that they had never used their cards, some may have been auto-enrolled and may not have understood what portion of their costs are being paid by the $600 credit and what was being paid by their SPAP or MA plan. In these cases, the $600 in TA was being utilized, but the beneficiary was experiencing a seamless coordination of benefits between the drug card transitional assistance and the other benefit. That is, beneficiaries may not have understood that the $600 credit was being accessed and applied to the costs of their drugs, whether they "used" their actual drug card or not.

According to both surveys, those without T.A. were more likely than those with T.A. to indicate that they had never used their drug card. As discussed above, some focus group participants reported that they had found other ways to get reduced prices on prescription drugs, which yielded a lower price than did a Medicare-Approved Drug Discount Card; this may be one reason that some of the survey respondents without T.A. were not using their cards. Focus group participants also explained that they don't actually have to "use" their cards when they fill prescriptions. After their first visit to the pharmacy, the information from their cards is recorded in the pharmacy data system and every subsequent prescription is processed through the card sponsor. Some survey respondents may be experiencing the same practice, and thus may have reported that they are not using their cards, even though their pharmacies are using the card sponsor information to process discounts and T.A. credit on their behalf.

2.3.3 Reasons for Not Using Card

Survey respondents who reported never using their cards were asked why they had not. The main reasons for not using the drug card was a lack of prescriptions to fill since receiving the card (over a quarter of non-card using respondents cited this reason; Exhibit 12). Respondents with T.A. were more likely than their counterparts to not use the card due to a lack of prescriptions.

The second most common reason cited by respondents was the use of another card or insurance that offered a better price (25 percent of 2004 respondents and 21 percent of 2005 respondents). This finding is consistent with reports from many focus group participants who had found better prices through other means. Eighteen percent of respondents to each of the surveys indicated that the card did not offer discounts on the drugs they purchased. Since most did not compare cards or did not know that there were many cards to choose from, they did not try to find another card that might have offered discounts – or better discounts – on their drugs.

Exhibit 12: Reasons for Not Using Medicare-Approved Drug Discount Card When Filling Prescriptions

	2004 Survey			2005 Survey		
IF NEVER USED THE CARD: Why have you not used your Medicare-Approved Drug Discount Card when filling a prescription?	**All Respondents Non-exclusive cards**	**T.A.**	**Non-T.A.**	**All Respondents Non-exclusive cards**	**T.A.**	**Non-T.A**
	n=2,860	**n=1,032**	**n=1,828**	**n=1,295**	**n=586**	**n=709**
No Prescriptions To Fill Since Getting Card	27%	46%***	22%	27%	42%***	22%
Pharmacy Would Not Accept Card	9%	9%	8%	11%	9%**	11%
Card Does Not Offer Discounts on Drugs I Buy	18%	14%***	20%	18%	12%***	19%
Forgot Card or Did Not Have Card With Me	4%	5%**	4%	*NA*	*NA*	*NA*
Usually Use Another Card Which Gives Me Better Price	25%	12%***	29%	21%	12%***	24%
Use another store w/better prices	*NA*	*NA*	*NA*	12%	5%***	14%
Other reason	*NA*	*NA*	*NA*	25%	25%***	25%
Did Not Answer	1%	1%***	2%	7%	7%*	7%

Sources: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Fall 2004; 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.

Note: Respondents could check more than one category. Therefore, tests of significant differences between T.A. and Non-T.A. card enrollees are at the category level (rows) and totals do not sum to 100%.

* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01

NA: Question was not asked on both the 2004 and the 2005 surveys.

2.3.4 Satisfaction

Survey respondents were asked how satisfied they were with various aspects of the Medicare-Approved Drug Discount Cards. Most expressed overall satisfaction with their cards (55 percent of the 2004 respondents and 68 percent of the 2005 respondents; Exhibit 13). Respondents were especially satisfied with the choice of pharmacies (70 percent in each of the surveys) and with the enrollment process (64 percent in each of the surveys). Satisfaction with savings was a little lower, with 50 percent of the respondents to the 2004 survey and 58 percent of respondents to the 2005 survey expressing satisfaction with savings.[17]

Exhibit 13: Overall Satisfaction with Card

	2004 Survey			2005 Survey		
Overall, how satisfied are you with your Medicare-Approved Drug Discount Card?	**All Respondents Non-exclusive cards**	**T.A.**	**Non-T.A.**	**All Respondents Non-exclusive cards**	**T.A.**	**Non-T.A**
	n=21,002	**n=10,976*** **	**n=10,026**	**n=11,575**	**n=7,823*** **	**n=3,752**
Somewhat or Very Satisfied	55%	78%	40%	68%	84%	52%
Neither Satisfied or Dissatisfied	7%	4%	10%	6%	2%	11%
Somewhat or Very Dissatisfied	19%	4%	28%	11%	3%	20%
Do Not Know	9%	7%	11%	3%	2%	4%
Did Not Answer	10%	7%	11%	11%	9%	13%

Sources: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Fall 2004; 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.
* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01

Survey respondents with T.A. were more satisfied than were those without T.A., on every satisfaction measure, in both surveys. This is consistent with findings from focus group T.A. participants, who were very positive about their experiences with their drug cards and especially their savings with the $600 credit.

Survey respondents who had considered more than one drug discount card were only a little more likely to be satisfied with their card, compared with those who had not considered more than one card. Apparently engaging in the choice process made only a small difference in respondents' satisfaction with the cards they chose. Current health status had little effect on satisfaction with drug cards.

[17] In the 2005 survey, only respondents who had used their drug discount cards were asked to answer questions regarding satisfaction with drug card features. Some of the differences in responses regarding satisfaction between the two surveys could be attributed to this difference in response group.

Respondents who used their cards every time they filled a prescription were much more likely to be satisfied with their cards than were those who used their cards only rarely. Again, this is in part a reflection of the greater satisfaction among those with T.A., who always used their cards and were also quite satisfied.

The relationship between taking many prescription medications and satisfaction was Inconclusive. Results from the 2004 survey indicate that satisfaction with the drug card increased with the number of prescription drugs a respondent was taking. However the 2005 survey indicates that respondents who were taking more prescriptions were less satisfied.

Many respondents who were currently taking no prescription drugs at all expressed satisfaction with their drug discount cards. Of those taking no prescriptions, 26 percent of 2004 respondents and 54 percent of 2005 respondents were very or somewhat satisfied. It is not clear why this group was so satisfied (or why satisfaction increased so dramatically between the surveys), since they apparently had no prescription costs and hence gained nothing from the available discounts and T.A. subsidy. Perhaps these respondents were largely enrolled in free cards and appreciated having the discounts and subsidy available at no cost, should they need them.

2.3.5 Problems Using Drug Cards

In each of the surveys, respondents were asked if they had certain problems using their Medicare-Approved Drug Discount Cards. In the 2004 survey, all survey respondents were asked to answer this question. In the 2005 survey, only those respondents who had used their drug card were asked to answer the question. Responses in the two surveys were noticeably different, with many more respondents to the 2004 survey reporting problems.

The problem most commonly mentioned by the 2004 survey respondents was finding a pharmacy that would accept their card (cited by 54 percent of survey respondents; Exhibit 14). Respondents with T.A. faced this problem more than those without (64 percent versus 48 percent). The second most common problem was getting a satisfactory price (21 percent). Respondents without T.A. were more likely to indicate this problem than those with T.A. Sixteen percent of respondents reported having a difficult time determining when the card would help.

Among those responding to the 2005 survey, the most common problem was that the card did not save much money, with 30 percent of respondents reporting this problem.[18] Respondents without T.A. were more likely than those with T.A. to cite this problem (48 percent versus 13 percent). Twelve percent of respondents had difficulties determining when the card helped, with non-T.A. respondents again more likely to cite this problem. The portion of respondents having difficulties finding a pharmacy dropped dramatically from the previous year: only four percent of respondents to the 2005 survey reported having a problem finding a pharmacy that would accept their card. It is likely that pharmacy acceptance was a short-term problem that was quickly resolved for most beneficiaries.

[18] Respondents to the 2004 survey were not aware of the specific prices they were paying for drugs but were aware of the overall amount they were spending. For this reason, the question regarding prices that was in the 2004 survey was replaced with a question about overall savings in the 2005 survey.

Almost all 2004 respondents indicated they had some problem with their drug card. Only one percent of 2004 respondents did not answer this question. In contrast, 57 percent of 2005 respondents did not answer this question.[19] Some may have simply skipped the question, but it appears that 2005 respondents experienced fewer problems with their drug cards. Again, problems that occurred early were probably resolved by the time of the second survey in the spring of 2005.

Exhibit 14: Problems Using Medicare-Approved Drug Discount Card

	2004 Survey			2005 Survey		
Have you had any of the following kinds of problems when trying to use your Medicare-Approved Drug Discount Card?	**All Respondents Non-exclusive cards**	**T.A.**	**Non-T.A.**	**All Respondents Non-exclusive cards**	**T.A.**	**Non-T.A**
	n=21,002	**n=10,976**	**n=10,026**	**n=11,575**	**n=7,823**	**n=3,752**
Finding Pharmacy to Take Card	54%	64%***	48%	4%	5%***	4%
Getting Prices I am Satisfied With	21%	10%***	28%	*NA*	*NA*	*NA*
Figuring Out When Card Helps	16%	9%***	21%	12%	8%***	17%
Card Did Not Save Much Money	*NA*	*NA*	*NA*	30%	13%***	48%
Other Problem Using Card	17%	21%	15%	4%	4%***	4%
Did Not Answer	1%	0.4%***	1%	57%	74%***	40%

Sources: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Fall 2004; 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.
Note: Respondents could check more than one category. Therefore, tests of significant differences between T.A. and Non-T.A. card enrollees are at the category level (rows) and totals do not sum to 100%.
* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01
NA: Question was not asked on both the 2004 and the 2005 surveys.

Although 54 percent of respondents to the 2004 survey indicated that they had difficulties finding a pharmacy that would accept their drug discount card; 70 percent of respondents to that same survey reported being very or somewhat satisfied with the choice of pharmacies that were available to them. These two findings appear to be contradictory and reflect inconsistent responses: those who said they had problems finding a pharmacy were more likely than others to say they were very or somewhat satisfied with the choice of pharmacies that accept the drug discount card. One explanation may be that finding a pharmacy that would accept a card was an early problem that quickly resolved (these survey respondents being among the earliest card users). The dramatic change in response to the 2005 survey supports this explanation.

Focus group participants who were enrolled in Medicare-Approved Drug Discount Cards were also asked about any problems they had experienced when using their cards. In 2004, participants in several focus groups mentioned that their pharmacists didn't seem to fully understand how the program worked, particularly the T.A. credit and how it should be applied in conjunction with SPAP or other benefit/discount programs. By the winter of 2005, however, few focus group participants reported any problems at all and said they simply took their cards to their pharmacists who entered the data into the computer systems. When these beneficiaries had other discount cards from other

[19] Respondents did not have the option to indicate they did not have a problem, so the lack of an answer could mean they did not have a problem.

programs, they trusted their pharmacists to figure out which would be most advantageous for a given prescription. It appears that pharmacist confusion was an early problem that was quickly overcome. In addition, many beneficiaries rely on pharmacists to figure out how to achieve the lowest out-of-pocket costs, rather than trying to figure this out themselves.

A few focus group participants reported difficulty in figuring out what they would have to pay for a specific drug, or whether their card would offer discounts on all their medications. And a number of those with T.A. wanted to track their benefit balance but reported problems in finding out how much of their $600 credit remained. Some reported seeing their balance printed on their pharmacy receipts, others said that they asked their pharmacists for this information but their pharmacists did not provide it.[20]

2.3.6 Help with Problems

Respondents to the 2004 survey were asked where they would turn for help if they had problems with their Medicare-Approved Drug Discount Cards (this question was not included in the 2005 survey). Forty-three percent said they would contact the sponsor of their card, 43 percent would call 1-800-MEDICARE, and 48 percent would ask their pharmacist for help. The latter supports previous findings that beneficiaries rely on their pharmacists when accessing pharmacy assistance/benefit programs.

Although survey respondents experienced occasional problems in using their drug cards, and knew where they would turn for help if they had a problem, few had sought any sort of help. Those few respondents who did contact their card sponsor were largely satisfied with the customer service offered by their card sponsor; respondents with T.A. were more likely to have contacted their card sponsor and also more likely to be satisfied with the customer service their sponsor provided, than those without T.A.

[20] All pharmacists should have been able to access this information from card sponsors, either electronically or by phone, and were required (per their contracts with card sponsors) to provide this information to card enrollees at point of sale, when asked.

2.3.7 Savings

Respondents to the 2004 survey said that before receiving their cards, they expected the cards would yield real savings (this question was not repeated in the 2005 survey). Twenty-nine percent expected to save a lot of money when using the card and 37 percent expected to save some money; a total of 66 percent expected to see savings – very high expectations. Survey respondents with T.A. expected to save more, which is reasonable since they were looking forward not only to discounts, but the $600 credit.

Both surveys queried respondents regarding how much money they had actually saved with their drug cards. Forty-six percent in 2004 and 57 percent in 2005 reported that they had saved either some or a lot of money (Exhibit 15). Survey respondents with T.A. were more likely than those without T.A. to report having saved a lot of money with their cards.

Exhibit 15: Card Savings

	2004 Survey			2005 Survey		
Overall, how much money do you think you have saved by using your Medicare-Approved Drug Discount Card?	**All Respondents Non-exclusive cards**	**T.A.**	**Non-T.A.**	**All Respondents Non-exclusive cards**	**T.A.**	**Non-T.A**
	n=21,002	**n=10,976*** **	**n=10,026**	**n=11,575**	**n=7,823*** **	**n=3,752**
A Lot	23%	47%	8%	32%	53%	11%
Some	23%	22%	23%	25%	24%	27%
A little	21%	7%	31%	22%	7%	36%
None	12%	5%	17%	3%	1%	6%
Do Not Know	13%	13%	12%	10%	9%	11%
Did Not Answer	8%	6%	9%	8%	6%	9%

Sources: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Fall 2004; 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.

* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01

Each survey also asked respondents whether they had saved more or less than expected. As displayed in Exhibit 16, about a third of the respondents (mostly those without T.A.) reported saving less than they'd expected. Nineteen percent of 2004 respondents and 23 percent of 2005 respondents indicated that they had saved more than expected (mostly those with T.A.). These findings are all consistent with the greater satisfaction with savings expressed by those receiving the T.A. credit.

Exhibit 16: Expected Savings

	2004 Survey			2005 Survey		
When you use your Medicare-Approved Drug Discount Card, do you save as much money as you expected?	**All Respondents Non-exclusive cards**	**T.A.**	**Non-T.A.**	**All Respondents Non-exclusive cards**	**T.A.**	**Non-T.A**
	n=21,002	**n=10,976*** **	**n=10,026**	**n=11,575**	**n=7,823*** **	**n=3,752**
Save More Than Expected	19%	38%	6%	23%	39%	6%
Save About What Expected	21%	27%	18%	27%	32%	22%
Save Less Than Expected	32%	11%	45%	29%	11%	48%
Do Not Know	19%	17%	20%	12%	11%	14%
Did Not Answer	10%	7%	12%	9%	7%	10%

Sources: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Fall 2004; 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.

* 0.05<p<=0.10; ** 0.01<p<=0.05; *** p<=0.01

Focus group participants were asked whether they thought they were getting the best price possible with their cards and whether they had done any comparison shopping among pharmacies to see which gave the best price for their medications. Most participants did not know if they were getting the best possible price, and did not know how to figure this out. Focus group participants who did try to comparison shop (about 25–30 people) reported that this was rather difficult to do. Some pharmacists would not (perhaps could not) provide prices unless the customer went in-person and gave the pharmacist their card and their prescription to process. Some pharmacists explained to these "shoppers" that there was an administrative fee each time they queried a card sponsor's database, and they were not willing to incur this fee unless a sale was pending. Other pharmacists said they were simply too busy to provide information for comparison shoppers. Those few beneficiaries who were able to get information and really comparison shop, were generally pleased with the results, although some found that prices varied so little that comparison shopping was not worth the effort.

Focus group participants with T.A., while generally quite satisfied with savings and with their drug cards overall, often had difficulty determining how much of their $600 credit remained and thus did not know when it would run out. Although this was more of a problem in 2004, some participants in the 2005 focus groups continued to report that they could not get this information from their pharmacists, while others saw this information printed out on their pharmacy receipts. Many beneficiaries with T.A. wanted to track their benefit and know when it would run out, and were frustrated when they thought this would not be possible. Some with T.A. also worried about how they would continue to pay for their prescriptions when the $600 credit was exhausted.

2.3.8 Prescription Filling Practices

Approximately ten percent of respondents to each of the surveys had in the past purchased drugs via mail order; this is apparently not a common practice among Medicare beneficiaries who enrolled in drug discount cards. Almost none of the respondents to the 2004 survey had bought drugs over the Internet (this question was not repeated in the 2005 survey) and focus groups findings indicate that most beneficiaries do not have Internet access. While some beneficiaries had helpful relatives or friends who were Internet-comfortable, this does not appear to have translated into making prescription drug purchases online.

Survey respondents were asked if they had ever delayed/skipped filling prescriptions, or delayed/skipped taking medication doses, prior to getting their Medicare-Approved Drug Discount Cards, and then were asked if they were doing these things after getting their cards. (Note that the *before* period was life-long compared to the *after* period of only two to four months.) Just under half of the respondents to each of the surveys reported that before getting their cards, they had at times decided not to fill a prescription because they couldn't afford it. And in each survey, respondents with T.A. were more likely than those without T.A. to indicate that they had at times not filled prescriptions before receiving the drug card. This was to be expected since those who qualified for T.A. were of limited Income and may have had difficulty paying for their drugs in the past.

A much smaller proportion indicated that they still found it necessary to sometimes delay/skip filling a prescription because they couldn't afford it, after receiving their Medicare-Approved Drug Discount Card (20 percent of 2004 survey respondents and 18 percent of 2005 respondents). The practice of not filling prescriptions due to cost declined. The improvement for those with T.A. was so great that they became less likely to not fill a prescriptions than were respondents without T.A. This may have been because most of those with T.A. had probably not yet exhausted their $600 credit at the time of the survey.

A number of focus group participants with T.A. were enthusiastic about their ability to fill their prescriptions and take their medications as prescribed. Many had in the past skipped doses of costly drugs, decided against filling prescriptions, shared prescriptions with friends, etc. and knew that this was sub-optimal. Others had dropped prescription insurance they previously held, because they could no longer afford the premiums, and a few had experienced a decline in a former employer's retiree benefits that reduced or eliminated their prescription coverage. The $600 credit eased all of these situations, at least temporarily, and many beneficiaries reported real relief at being able to afford to take their medications properly.

2.4 Detailed Programmatic Knowledge

2.4.1 Understanding Programmatic Features

Ideally, participants in any insurance or benefit program would have a fairly complete understanding of how the program works – the "rules of the road". Focus group participants were asked how they would explain the Medicare drug discount card program to a friend: how it works and what one can get through the program. Few were able to explain the program; even those who had enrolled and were using their cards were not able to fully explain the program, although most could describe a few features such as the $600 credit, discounts, and the temporary nature of the program.[21] The aspect of the program beneficiaries understood most clearly was that they needed to present their Medicare-Approved Drug Discount Card to the pharmacist when filling a prescription (at least the first time), in order to receive a discount. Card enrollees often had experience with other discount programs/cards that worked the same way. There was considerable confusion among those with T.A. in terms of how the $600 credit works in conjunction with discounts/benefits from other programs, SPAPs, etc. Focus group participants in fall 2004 were more confused than those participating in 2005, probably because the program was so new in 2004.

To assess survey respondents' understanding of programmatic features, they were asked to evaluate whether five specific statements about the program were correct or incorrect. These questions were: whether having a Medicare-Approved Drug Discount Card is the same as having insurance; whether a beneficiary can have only one Medicare-Approved Drug Discount Card at a time; whether the cards yield discounts on all prescription drugs at any pharmacy; whether a card enrollee can also have other discount cards sponsored by drug manufacturers or drug store chains; and whether the price paid when using a card depends on generic vs. brand name purchases.

A slight majority of respondents answered one of the five questions correctly (price paid depends on generic vs. brand name drugs), with over 50 percent of respondents to each of the surveys understanding this feature (Exhibit 17). Only a minority of respondents to each survey answered the other questions correctly. Of perhaps most concern were the respondents who were under the mistaken impression that if they had a Medicare-Approved Drug Discount Card they could not also have a discount card from another source like a drug manufacturer or drug store (approximately 15 percent in each of the surveys). It appears that some fairly basic aspects of the program are not well understood, even by those who are enrolled and the level of understanding did not improve noticeably between fall 2004 and spring 2005.

[21] It should be noted that the focus groups and Fall 2004 survey were conducted before active outreach and information campaigns regarding the Medicare Prescription Drug Program started. The Spring 2005 survey was field at about the time these campaigns were starting.

Exhibit 17: Understanding of Programmatic Features (correct answers indicated by shading)

Survey Questions	2004 Survey				2005 Survey			
	Agree	Disagree	Do Not Know	Did Not Answer	Agree	Disagree	Do Not Know	Not Answered
C8: A Medicare-Approved Drug Discount Card is the same as having insurance for prescription drugs.	24%	34%	30%	12%	25%	32%	34%	9%
C9: You can only have one Medicare-Approved Drug Discount Card at a time.	47%	10%	28%	14%	41%	11%	38%	10%
C10: With a Medicare-Approved Drug Discount Card you get discounts on all prescription drugs, at any pharmacy.	20%	34%	33%	14%	21%	31%	37%	10%
C11: If you have a Medicare-Approved Drug Discount Card, you can also have other discount cards sponsored by drug manufacturing companies or drug store chains.	23%	16%	47%	14%	23%	15%	53%	9%
C12: When you use your Medicare-Approved Drug Discount Card, the price you pay will depend on whether you are buying a generic drug or a brand name drug.	52%	7%	28%	13%	52%	7%	33%	8%

Sources: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Fall 2004; 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.

2.4.2 Medicare Drug Coverage Program (Part D) Knowledge

During focus groups held in winter 2005, participants were asked whether they had heard about changes coming in the drug program, and what they had heard or knew about these changes. Again, awareness was quite high that changes were coming, but few participants had specific information about these upcoming changes. Seventy-six percent of those without T.A. in the focus groups knew changes were coming, 74 percent of non-enrollees knew changes were coming, and 55 percent of those with T.A. were aware of upcoming changes. In eight of the 24 focus groups held in 2005, not a single person could describe anything they had heard about upcoming changes, or were so confused

about what they had heard that they were not comfortable trying to relay this information. Among those who had heard about changes, some knew that the drug cards they held would no longer be valid, that the program would remain voluntary, that there would be a monthly premium rather than an annual enrollment fee, that there would be a coverage gap, and that those with very high drug costs could qualify for more help. A very few mentioned more precise details like a deductible amount or the penalty for delayed enrollment, which was perceived by a few as being much higher than it actually will be.

Since awareness of impending change was high, but detailed understanding quite low, few focus group participants had formed any opinions about the upcoming changes and therefore had not decided whether they would participate in Part D. They did not know whether they would stay with the same sponsor (assuming that the card sponsor intended to offer a drug plan in 2006) and most were waiting to learn more before forming any opinions or making decisions.

2.5 Changes between 2004 and 2005 Surveys

The Non-Exclusive Card enrollees who responded to the 2005 survey were not noticeably different from those who responded to the 2004 survey, with the exception of the following: T.A. respondents in 2005 reported a higher rate of Medicaid enrollment than in 2004, fewer T.A. respondents reported access to free drugs in 2005, and more T.A. respondents reported an absence of help in paying for drugs in 2005 (aside from their Medicare drug discount cards). The higher percentage of those with T.A. reporting dual-eligibility for Medicare and Medicaid may limit the comparability between the two surveys of the Non-Exclusive card enrollees with T.A.[22]

There were remarkably few differences in the responses of Non-Exclusive card enrollees between the 2004 and 2005 surveys, and very little improvement in knowledge about various programmatic features. The following few differences between the two surveys may indicate some impact of the passage of time and additional experience with drug discount cards.[23]

- Although the drug discount card program had been in effect for one year at the time of the second survey, the awareness of being enrolled among Non-Exclusive card enrollees declined between 2004 and 2005. It is unclear why the lack of awareness of enrollment, among beneficiaries who had to take action to enroll, declined over time.

- Compared to 2004, more Non-Exclusive card enrollees with T.A. in 2005 were aware of their enrollment in the T.A. program, probably because most had nearly a year of enrollment during which to understand their status. Thus although overall awareness of enrollment declined, awareness of the T.A. subsidy among those who received it, improved.

[22] Beneficiaries with Medicaid (dual-eligibles) were not supposed to be eligible for drug discount cards and we should not have seen such a high percentage of the 2005 respondents indicating Medicaid enrollment, since all were also enrolled in drug discount cards. These respondents may have been mistaken about their Medicaid status. Some individuals who reported having Medicaid, however, may have been Medicare Savings Program beneficiaries, eligible for partial Medicaid benefits without drug coverage. Beneficiaries with this partial benefit would have been eligible for Medicare-approved drug discount cards. The number of such people may have increased in 2005 because of CMS facilitated enrollment efforts in late 2004.

[23] The fact that the two samples were different and the surveys were slightly different, means that these changes could be due to other factors as well.

- Compared to 2004, there is a slight increase in the percent of Non-Exclusive card enrollees who considered more than one card before making a choice, but in both surveys fewer than one in three considered more than one card.

- There was a slight decrease in the number of respondents reporting having never used their drug card and a slight increase in the number of respondents reporting using their drug card every time they filled a prescription.

- In 2005, Non-Exclusive card enrollees reported higher overall satisfaction ratings than the comparable group in 2004. Again this was probably because respondents in 2005 had more time to locate accommodating pharmacies, use their cards, and understand the associated benefits.

- Fewer problems using drug discount cards were reported in 2005. Compared to 2004, there was a dramatic reduction in the number of respondents reporting difficulty finding a pharmacy where they could use their drug discount card.

- In 2005, more Non-Exclusive card enrollees reported saving money with the drug card than in 2004 and a higher rate of saving more money than they'd expected. This could reflect more time to realize savings.

These few changes between the two surveys may reflect gains due to experience with the drug cards, among other factors. Early findings may not always persist, as beneficiaries gain experience with a new program like the drug discount cards. The fact that there were so few changes, however, speaks to the persistence of early findings for many measures included in these surveys.

2.6 Card Level Analysis

In addition to the above analysis, survey data were analyzed at the card-level to determine whether or not differences existed between the responses of card holders from different cards and whether certain Medicare-Approved Drug Discount Cards performed "better" or "worse" on key card measures. Survey questions addressing enrollee awareness, satisfaction, card use, problems, and savings were included in this card-level analysis.

Cards were selected for each survey based on which cards were the largest in the nation at the time the survey was fielded. For this reason, some of the cards were sampled for only one survey. A number of the largest cards, however, were sampled for both surveys, since they were the largest cards at the time each sample was selected. ***The four surveyed Exclusive cards are not included in these cross card comparison results.***

To facilitate cross card comparisons, only the portion of respondents who submitted 'valid' responses are included in the following analyses. Respondents who did not answer a question or indicated they did not know the answer to a question were removed from the denominator of each of the percents in the cross card comparison tables. For this reason, the number of respondents included in the analysis varies from question to question.

2.6.1 Awareness

Awareness of Program, by Card

Respondents were asked if they had a card with the Medicare-approved Rx logo on it and if they had received the $600 credit from Medicare. These responses were compared with data from CMS administrative files.

Although all survey respondents were enrolled in a Medicare-Approved Drug Discount Card at least two months prior to the survey (according to CMS administrative files), some drug cards' respondents were more aware of having a drug card. Awareness of having the drug card for 2004 respondents ranged from 55 percent (National 6) to 97 percent (National 8) (Exhibit 18). According to the 2005 survey results, awareness of having the drug card ranged from 33 percent (both National 14 and National 16) to 77 percent (National 12). Only those respondents who were aware that they had a Medicare-Approved Drug Discount Card were asked to complete the remainder of the survey.

Exhibit 18: Awareness of Card, by Card

	2004 Survey (n=24,639)			2005 Survey (n=19,154)			
	% Who Have Card	% Without Card	% Who Don't Know if Have Card	% Who Have Card	% Applied, but Haven't Received Card	% Without Card	% Who Don't Know if Have Card
Regional 1	68%	28%	3%				
Regional 2	58%	39%	3%				
Regional 3	85%	13%	2%	74%	1%	21%	4%
Regional 4	75%	23%	2%	68%	2%	25%	5%
Regional 5	81%	17%	2%				
Regional 10				69%	2%	26%	4%
Regional 19				65%	1%	31%	4%
Regional 29				75%	1%	20%	4%
Regional 30				60%	2%	34%	3%
National 1	84%	14%	2%				
National 2	76%	21%	3%				
National 3	94%	5%	1%				
National 4	91%	8%	1%	54%	2%	41%	3%
National 5	79%	20%	1%	61%	1%	34%	4%
National 6	55%	43%	3%	52%	2%	40%	6%
National 7	90%	9%	2%	36%	2%	56%	6%
National 8	97%	2%	1%	64%	1%	33%	2%
National 9	88%	11%	1%				
National 10	92%	7%	1%	64%	1%	31%	4%
National 11	87%	12%	1%	72%	2%	23%	3%
National 12	87%	12%	1%	77%	1%	19%	2%
National 13				34%	2%	59%	6%
National 14				33%	1%	59%	7%
National 15				34%	2%	59%	6%
National 16				33%	1%	59%	6%
National 22S				69%	2%	26%	3%
National 24				39%	3%	53%	5%
National 27S				72%	1%	24%	3%
National 29				51%	1%	42%	6%
National 30S				76%	1%	18%	4%

Sources: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Fall 2004; 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.
Note: Data are adjusted for non-response and weighted to reflect the size and composition of the sampled card populations. Shaded cells represent the cards that were not included in one survey or the other; only 10 cards were included in both surveys.

Awareness of Credit

Survey respondents who had the T.A. credit (according to CMS files) were asked whether they had received the $600 credit from Medicare (Exhibit 19). Among persons with T.A., awareness of receiving the $600 credit from Medicare varied considerably in both surveys.

In the 2004 survey results, there was about a 70-percentage point difference between the cards with the lowest and highest portion of T.A. respondents that were aware they received the credit. Only 20 percent of the T.A. respondents in drug card National 2 reported that they had received the $600 credit. In contrast, 89 percent of the T.A. respondents in drug card National 8 reported that they had received the $600 credit. National 2 was, however, an outlier. Awareness of the T.A. credit was over 65 percent in 15 of the 17 drug cards.

According to the 2005 survey results, there was a 25-percentage point difference between the cards with the lowest and highest portion of T.A. respondents that were aware they received the credit. Only 58 percent of the T.A. respondents in drug cards Regional 10 reported that they had received the $600 credit. In contrast, 83 percent of the T.A. respondents in drug card National 8 reported that they had received the $600 credit.

Exhibit 19: Awareness of T.A. Credit, by Card

Drug Card	2004 Survey (n=10,460)			2005 Survey (n=7,967)		
	% Received $600 Credit	% Did Not Receive $600 Credit	% Don't Know if Received $600 Credit	% Received $600 Credit	% Did Not Receive $600 Credit	% Don't Know if Received $600 Credit
Regional 1	66%	22%	13%			
Regional 2	50%	23%	27%			
Regional 3	71%	14%	16%	78%	8%	14%
Regional 4	78%	8%	14%	79%	8%	13%
Regional 5	74%	12%	14%			
Regional 10				58%	19%	23%
Regional 19				78%	10%	13%
Regional 29				76%	10%	14%
Regional 30				75%	7%	17%
National 1	84%	5%	11%			
National 2	20%	41%	39%			
National 3	86%	6%	9%			
National 4	88%	4%	8%	80%	6%	14%
National 5	75%	9%	16%	72%	14%	14%
National 6	73%	11%	17%	73%	12%	15%
National 7	79%	7%	15%	70%	10%	20%
National 8	89%	4%	7%	83%	5%	12%
National 9	84%	6%	10%			
National 10	82%	7%	11%	74%	13%	13%
National 11	79%	8%	13%	78%	10%	12%
National 12	83%	4%	13%	82%	5%	13%
National 13				79%	6%	15%
National 14				75%	8%	17%
National 15				75%	9%	17%
National 16				82%	6%	12%
National 22S				80%	7%	13%
National 24				73%	8%	19%
National 27S				77%	9%	14%
National 29				74%	10%	16%
National 30S				73%	8%	19%

Sources: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Fall 2004; 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.
Note: Data are adjusted for non-response and weighted to reflect the size and composition of the sampled card populations. Shaded cells represent the cards that were not included in one survey or the other; only 10 cards were included in both surveys.

2.6.2 Card Use

Respondents from different cards reported different levels of card use. Some cards had more respondents who used their card every time they filled a prescription, others had more respondents who reported never using their cards.

In the 2004 survey, only 45 percent of the respondents in drug card Regional 2 used their card every time they filled a prescription (Exhibit 20). In contrast, 80 percent of the respondents enrolled in drug card National 8 used their Medicare-Approved Drug Discount Card every time (a 35 percentage point difference between the cards with the lowest and highest portion of respondents that used their card every time they filled a prescription).

In the 2005 survey, only 63 percent of the respondents in drug cards National 6 and National 14 used their card every time they filled a prescription. In contrast, 83 percent of the respondents enrolled in drug card Regional 3 used their Medicare-Approved Drug Discount Card every time they filled a prescription (a 20 percentage point difference between the cards with the lowest and highest portion of respondents that used their card every time they filled a prescription).

The portion of respondents reporting never using the drug card varied as well. In the 2004 survey there was a 30 percentage point difference between the cards with the lowest and highest proportion of respondents who never used their card when filling a prescription. Only six percent of those from drug card National 8 had never used their drug discount card, while 35 percent of those from drug cards Regional 2 and Regional 5 had never used their drug discount card.

In the 2005 survey, there was a 21 percentage point difference between the cards with the lowest and highest proportion of respondents who never used their card when filling a prescription. Only five percent of those from drug card Regional 3 had never used their drug discount card, while 26 percent of those from drug card National 14 had never used their drug discount card.

Exhibit 20: Frequency of Card Use When Filling Prescriptions, by Card

	2004 Survey (n=20,147)					2005 Survey (n=11,843)				
Drug Card	Every Time	Most of the Time	Some of the Time	Rarely	Never	Every Time	Most of the Time	Some of the Time	Rarely	Never
Regional 1	57%	4%	8%	5%	27%					
Regional 2	45%	6%	4%	9%	35%					
Regional 3	76%	4%	4%	2%	13%	83%	5%	3%	3%	5%
Regional 4	68%	5%	4%	3%	19%	73%	8%	2%	3%	14%
Regional 5	46%	7%	6%	6%	35%					
Regional 10						67%	5%	3%	7%	17%
Regional 19						67%	4%	4%	10%	15%
Regional 29						70%	5%	4%	3%	17%
Regional 30						77%	6%	2%	5%	10%
National 1	69%	5%	5%	3%	18%					
National 2	75%	2%	4%	5%	15%					
National 3	79%	6%	4%	3%	7%					
National 4	76%	7%	4%	3%	11%	76%	9%	3%	3%	9%
National 5	57%	5%	4%	5%	29%	65%	5%	5%	7%	18%
National 6	60%	2%	4%	9%	25%	63%	6%	4%	7%	20%
National 7	75%	6%	4%	3%	12%	69%	8%	6%	4%	13%
National 8	80%	8%	4%	2%	6%	77%	7%	5%	3%	9%
National 9	76%	6%	5%	3%	10%					
National 10	75%	6%	4%	2%	13%	73%	6%	5%	3%	14%
National 11	72%	7%	3%	3%	15%	73%	7%	3%	3%	15%
National 12	77%	10%	5%	2%	7%	80%	10%	4%	2%	5%
National 13						64%	4%	7%	2%	23%
National 14						63%	7%	2%	1%	26%
National 15						64%	5%	6%	4%	22%
National 16						75%	4%	4%	3%	15%
National 22S						79%	5%	3%	3%	10%
National 24						70%	4%	3%	4%	19%
National 27S						79%	5%	3%	3%	8%
National 29						72%	5%	4%	4%	15%
National 30S						81%	7%	3%	3%	7%

Sources: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Fall 2004; 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.

Note: Data are adjusted for non-response and weighted to reflect the size and composition of the sampled card populations. Shaded cells represent the cards that were not included in one survey or the other; only 10 cards were included in both surveys.

2.6.3 Satisfaction

Survey respondents enrolled in different cards expressed varying levels of satisfaction with their drug discount card. In the 2004 survey, there was a 38 percentage point gap between the cards with the lowest and highest portion of respondents indicating that they were either very or somewhat satisfied with their overall drug discount card (Exhibit 21). Only 46 percent of the respondents in drug card Regional 1 were either very or somewhat satisfied. In contrast, 84 percent of the respondents in drug card National 12 were very or somewhat satisfied overall with their Medicare-approved drug card.

In the 2005 survey, there was an even larger difference between the cards with the lowest and highest portion of very or somewhat satisfied respondents (43 percentage points). Only 49 percent of the respondents in drug card Regional 10 were very or somewhat satisfied, while 92 percent of the respondents in drug card National 29 were very or somewhat satisfied overall with their Medicare-approved drug card.

Similarly, some drug cards had more respondents who were either very or somewhat dissatisfied with their drug card. In the 2004 survey, only seven percent of those from drug card National 2 were very dissatisfied with their Medicare-Approved Drug Discount Card, while 42 percent of those from drug card Regional 1 were either very or somewhat dissatisfied. And in the 2005 survey, only four percent of those from drug card National 29 were very or somewhat dissatisfied with their Medicare-Approved Drug Discount Card, while 34 percent of those from drug card Regional 10 were very or somewhat dissatisfied.

Exhibit 21: Overall Satisfaction with Card, by Card

Drug Card	2004 Survey (n=18,138)			2005 Survey (n=10,012)		
	Very or Somewhat Satisfied	Neither Satisfied nor Dissatisfied	Very or Somewhat Dissatisfied	Very or Somewhat Satisfied	Neither Satisfied nor Dissatisfied	Very or Somewhat Dissatisfied
Regional 1	46%	12%	42%			
Regional 2	47%	14%	39%			
Regional 3	71%	8%	22%	72%	10%	18%
Regional 4	60%	11%	28%	68%	13%	19%
Regional 5	55%	13%	33%			
Regional 10				49%	17%	34%
Regional 19				50%	20%	31%
Regional 29				79%	9%	12%
Regional 30				90%	6%	5%
National 1	72%	8%	20%			
National 2	83%	10%	7%			
National 3	78%	6%	17%			
National 4	73%	10%	18%	77%	10%	13%
National 5	50%	13%	37%	62%	12%	26%
National 6	59%	10%	30%	69%	11%	20%
National 7	77%	6%	17%	86%	5%	9%
National 8	80%	7%	13%	84%	7%	9%
National 9	71%	9%	19%			
National 10	79%	6%	14%	85%	5%	9%
National 11	70%	7%	23%	76%	7%	17%
National 12	84%	6%	9%	85%	6%	9%
National 13				91%	2%	7%
National 14				87%	3%	10%
National 15				86%	6%	8%
National 16				90%	1%	8%
National 22S				80%	8%	13%
National 24				86%	5%	8%
National 27S				81%	9%	10%
National 29				92%	5%	4%
National 30S				86%	4%	10%

Sources: Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Fall 2004; 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.

Note: Data are adjusted for non-response and weighted to reflect the size and composition of the sampled card populations. Shaded cells represent the cards that were not included in one survey or the other; only 10 cards were included in both surveys.

2.6.4 Problems

The types of problems respondents had when trying to use their Medicare-Approved Drug Discount Card varied across the drug cards in the two surveys.

In the 2004 survey, there was an 18 percentage point difference between the cards with the lowest and highest portion of respondents having difficulties finding a pharmacy, with 44 percent of respondents in drug cards Regional 2 and National 6 having a problem finding a pharmacy, and 62 percent of those in drug cards National 2, National 10, and National 12 having this problem (Exhibit 22). The gap remained about the same size in the 2005 survey, though the proportion of respondents having difficulties finding pharmacies was much lower. Three percent of respondents in drug card Regional 4 had a problem finding a pharmacy, while 25 percent of those in drug card National 7 had this problem.

In the 2004 survey, there was a 21 percentage point difference between the cards with the lowest and highest proportion of respondents who had a problem getting satisfactory prices. Only nine percent of respondents in drug card National 2 had a problem getting satisfactory prices, while 29 percent of those in drug cards Regional 2 and National 6 had a problem.

The 2005 survey asked respondents if they had a problem with card savings instead of asking if they had a problem finding satisfactory prices. There was a 38 percentage point difference between the cards with the lowest and highest share of respondents who indicated that their card didn't save them much money. Forty-four percent of respondents in drug cards National 15 and National 29 had this problem, while 82 percent of respondents in Regional 3, Regional 10, and Regional 19 had this problem.

Both surveys asked respondents if they had a problem determining when their drug card helps and when other insurance, discounts or cards are better. In the 2004 survey there was a 16 percentage point difference between the cards with the lowest and highest share of respondents who had a problem determining when their drug card helps and when other insurance or cards are better. Only ten percent of respondents in drug card National 2 had a problem with figuring out when the drug card helps most, while 26 percent of respondents in drug card Regional 5 had this problem. In the 2005 survey, there was an 11 percentage point difference between the cards with the lowest and highest share of respondents who had a problem determining when their drug card helps and when other insurance or cards are better. Only 18 percent of respondents in drug card National 14 had a problem with figuring out when the drug card helps most, while 39 percent of respondents in drug card National 29 had this problem.

Exhibit 22: Problems with Drug Card

Drug Card	2004 Survey (n=20,838)			2005 Survey (n=11,575)		
	Finding Pharmacy To Take Card	Getting Satisfactory Prices	Figuring Out When Card is Helpful	Finding Pharmacy To Take Card	Figuring Out When Card is Helpful	Card Didn't Save Much
Regional 1	47%	26%	24%			
Regional 2	44%	29%	23%			
Regional 3	57%	19%	14%	6%	21%	82%
Regional 4	54%	22%	19%	3%	23%	81%
Regional 5	52%	24%	26%			
Regional 10				10%	34%	82%
Regional 19				5%	31%	82%
Regional 29				15%	32%	55%
Regional 30				11%	33%	63%
National 1	54%	18%	18%			
National 2	62%	9%	10%			
National 3	61%	20%	14%			
National 4	58%	18%	16%	9%	32%	71%
National 5	52%	27%	20%	7%	32%	80%
National 6	44%	29%	23%	15%	26%	80%
National 7	58%	17%	11%	25%	27%	50%
National 8	59%	18%	12%	9%	24%	69%
National 9	55%	18%	17%			
National 10	62%	17%	13%	22%	26%	61%
National 11	55%	20%	15%	11%	27%	73%
National 12	62%	15%	13%	8%	37%	60%
National 13				21%	25%	54%
National 14				30%	18%	56%
National 15				25%	27%	44%
National 16				21%	23%	53%
National 22S				9%	27%	75%
National 24				13%	34%	59%
National 27S				8%	30%	72%
National 29				12%	39%	44%
National 30S				8%	28%	68%

Sources: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Fall 2004; 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.
Note: Data are adjusted for non-response and weighted to reflect the size and composition of the sampled card populations. Shaded cells represent the cards that were not included in one survey or the other; only 10 cards were included in both surveys.

2.6.5 Savings

Respondents were asked how much money they felt they saved when using their drug discount cards. In the 2004 survey, the difference between the cards with the lowest and highest proportion of respondents who felt that they saved a lot of money with their drug card was 44 percentage points (Exhibit 23). Only six percent of respondents in drug card Regional 1 felt they saved a lot with their drug card, while 50 percent of those in drug card National 12 indicated that they had saved a lot. The share of respondents who indicated they had saved nothing with their drug card also varied across the 17 drug cards sampled in the 2004 survey. Only three percent of the drug card National 8 respondents felt that they saved nothing with their card, but 34 percent of those in drug card Regional 1 indicated they had saved nothing.

In the 2005 survey, the difference between the cards with the lowest and highest proportion who felt that they saved a lot with their drug card was 49 percentage points. Only nine percent of respondents in drug card Regional 19 felt they saved a lot with their drug card, while 58 percent of those in drug card National 13 indicated they had saved a lot. The share of respondents who felt they saved nothing with their drug card varied somewhat across the 23 drug cards in the 2005 survey. Only one percent of the respondents in drug cards National 12 and National 14 felt that they saved nothing with their card, but 12 percent of those in drug card Regional 10 felt they had saved nothing.

Exhibit 23: Savings, by Card

Drug Card	2004 Survey (n=17,729)				2005 Survey (n=9,579)			
	Have Saved a Lot with Card	Have Saved Some with Card	Saved a Little with Card	Saved Nothing with Card	Have Saved a Lot with Card	Have Saved Some with Card	Saved a Little with Card	Saved Nothing with Card
Regional 1	6%	23%	37%	34%				
Regional 2	11%	31%	27%	30%				
Regional 3	22%	33%	33%	13%	21%	36%	38%	5%
Regional 4	21%	32%	30%	17%	24%	27%	43%	6%
Regional 5	24%	21%	23%	31%				
Regional 10					10%	24%	54%	12%
Regional 19					9%	25%	55%	10%
Regional 29					42%	34%	20%	4%
Regional 30					55%	30%	13%	2%
National 1	38%	26%	21%	14%				
National 2	44%	21%	14%	21%				
National 3	43%	31%	19%	7%				
National 4	36%	34%	22%	9%	33%	31%	31%	5%
National 5	14%	22%	40%	24%	20%	28%	43%	8%
National 6	17%	31%	32%	19%	23%	24%	44%	10%
National 7	41%	28%	20%	12%	51%	28%	19%	3%
National 8	40%	36%	20%	3%	41%	34%	24%	2%
National 9	36%	32%	22%	11%				
National 10	45%	28%	19%	8%	46%	30%	20%	3%
National 11	36%	29%	22%	13%	39%	29%	29%	3%
National 12	50%	33%	12%	6%	53%	33%	14%	1%
National 13					58%	21%	18%	4%
National 14					51%	33%	15%	1%
National 15					54%	28%	11%	6%
National 16					42%	34%	19%	5%
National 22S					37%	32%	26%	6%
National 24					48%	29%	21%	2%
National 27S					35%	35%	28%	2%
National 29					52%	30%	16%	2%
National 30S					48%	29%	19%	4%

Sources: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Fall 2004; 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.

Note: Data are adjusted for non-response and weighted to reflect the size and composition of the sampled card populations. Shaded cells represent the cards that were not included in one survey or the other; only 10 cards were included in both surveys.

2.6.6 Card Level Ranking Across All Questions

Each question examined in the cross card analysis revealed variation across the different cards included in the sample. In addition to determining if variability between cards existed, we considered whether certain cards consistently performed "well" or "poorly" across many survey items. This was accomplished by providing ranks for each card, for each topic.

Cards were ranked according to respondent answers to questions in the five topics discussed previously: Awareness, Card Use, Satisfaction, Problems, and Savings. The following is a discussion of cards that performed well and of those that did poorly, across all five topics.

Cards sampled for the 2004 survey were ranked from 1 to 17 while cards sampled for the 2005 survey were ranked from 1 to 23. Rankings were based on the percentage of respondents who replied with the most positive answers. For example, in each of the following sections, a rating of 1 for "Problems with T.A. Credit" indicates the card with the highest portion of respondents indicating they had no problems using the T.A. credit.[24] Similarly, in the section that discusses the weakest cards, a rating of 1 for "Saved Nothing with Card" indicates the card with the smallest portion of respondents indicating they had saved nothing with their drug card. For two topics (Awareness and Satisfaction), rankings were based on combining the responses to multiple questions.

The cards that ranked in the top five for each of the five topics are shaded in gray in Exhibit 24 and Exhibit 26. The cards that ranked in the bottom five for each of the five topics are shaded in gray in Exhibit 25 and Exhibit 27.

Strongest Cards

Considering the ranking of cards based on the most positive answer to each topic of questions (awareness, use of drug cards, satisfaction, problems, and savings), a few cards were among the best cards for several ratings in the 2004 survey (Exhibit 24). No card ranked in the top five in all five topics. Only one card, National 3, ranked in the top five in four of the topics, though it did not rank first in any one topic. Three additional cards (National 8, National 10 and National 12) each ranked in the top five in three of the five topics.

[24] The question that asked respondents if they had problems using the drug card was not used for ranking cards according to problems because this survey question did not allow respondents to indicate that they had no problems using the card.

Exhibit 24: Rankings of Card Performance on Key Topics, Best Cards, 2004 Survey

	Awareness of Card and Credit	Frequency of Card Use	Satisfaction with Card Features	Problems with T.A. Credit	Saved a lot with Card
Regional 1	14	15	16	14	17
Regional 2	17	17	17	16	16
Regional 3	10	4	7	3	12
Regional 4	13	12	12	2	13
Regional 5	10	16	13	9	11
National 1	8	11	10	17	7
National 2	14	9	1	13	3
National 3	2	2	5	15	4
National 4	3	5	8	8	9
National 5	10	14	15	4	15
National 6	14	13	13	11	14
National 7	7	7	5	5	5
National 8	1	1	4	7	6
National 9	4	6	9	12	9
National 10	4	8	3	10	2
National 11	9	10	11	1	8
National 12	6	3	1	6	1

Source: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Fall 2004

Considering the ranking of cards based on the most positive answer to each topic of questions, no cards were among the best for more than three of the ratings in the 2005 survey results (Exhibit 25). Two cards, Regional 30 and National 29, were in the top five for three of the five topics. Six cards (Regional 3, National 11, National 12, National 13, National 14, and National 30S) were in the top five for two topics each.

Exhibit 25: Rankings of Card Performance on Key Topics, Best Cards, 2005 Survey

	Awareness of Card and Credit	Frequency of Card Use	Satisfaction Card Features	Problems with T.A. Credit	Savings with Card
Regional 3	2	5	11	6	20
Regional 4	8	9	19	6	18
Regional 10	15	15	23	23	22
Regional 19	10	21	22	14	23
Regional 29	3	11	18	21	11
Regional 30	12	1	4	6	2
National 4	13	4	15	6	17
National 5	14	16	21	15	21
National 6	16	21	20	15	19
National 7	23	17	9	14	6
National 8	9	19	13	5	13
National 10	11	6	12	6	10
National 11	3	20	17	1	14
National 12	1	13	9	6	4
National 13	19	12	2	19	1
National 14	22	3	5	15	6
National 15	21	8	7	12	3
National 16	18	18	6	3	12
National 22S	5	23	16	15	15
National 24	19	7	2	19	9
National 27S	6	14	14	22	16
National 29	17	10	1	1	5
National 30S	6	2	7	3	8

Source: 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.

Weakest Cards

In the 2004 survey, a number of cards were weak performers. Two cards, Regional 1 and Regional 2, ranked in the bottom five in all five topics (Exhibit 26). Four other cards ranked in the bottom five on three of the topics. It appears that certain cards consistently performed poorly on these measures.

Exhibit 26: Rankings of Card Performance on Key Topics, Weakest Cards, 2004 Survey

	Awareness of Card and Credit	Frequency of Card Use	Dissatisfaction with Card Features	Problems with T.A. Credit	Saved Nothing with Card
Regional 1	14	15	14	14	17
Regional 2	17	17	16	16	15
Regional 3	10	4	5	3	8
Regional 4	13	12	12	2	11
Regional 5	10	16	17	9	16
National 1	8	11	11	17	10
National 2	14	9	1	13	13
National 3	2	2	8	15	3
National 4	3	5	5	8	5
National 5	10	14	14	4	14
National 6	14	13	13	11	12
National 7	7	7	7	5	7
National 8	1	1	3	7	1
National 9	4	6	9	12	6
National 10	4	8	4	10	4
National 11	9	10	9	1	8
National 12	6	3	2	6	2

Source: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Fall 2004

There was less consistency in the 2005 survey results. No cards ranked in the bottom five on all five topics (Exhibit 27). Three cards (Regional 10, Regional 19 and National 6) each ranked in the bottom five in three of the topics. Four cards (National 5, National 11, National 13, and National 24) each ranked in the bottom five in two of the topics.

Exhibit 27: Rankings of Card Performance on Key Topics, Weakest Cards, 2005 Survey

	Awareness of Card and Credit	Frequency of Card Use	Dissatisfaction with Card Features	Problems with T.A. Credit	Saved Nothing with Card
Regional 3	2	5	13	6	14
Regional 4	8	9	16	6	17
Regional 10	15	15	23	23	23
Regional 19	10	21	22	14	21
Regional 29	3	11	18	21	11
Regional 30	12	1	1	6	3
National 4	13	4	15	6	14
National 5	14	16	20	15	20
National 6	16	21	21	15	21
National 7	23	17	11	14	8
National 8	9	19	9	5	3
National 10	11	6	14	6	8
National 11	3	20	19	1	8
National 12	1	13	4	6	1
National 13	19	12	7	19	11
National 14	22	3	5	15	1
National 15	21	8	6	12	17
National 16	18	18	10	3	14
National 22S	5	23	17	15	17
National 24	19	7	3	19	3
National 27S	6	14	12	22	3
National 29	17	10	2	1	3
National 30S	6	2	7	3	11

Source: 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Spring 2005.

2.6.7 Card Performance across Surveys

Ten cards were sampled for both the 2004 and 2005 surveys (Regional 3, Regional 4, National 4, National 5, National 6, National 7, National 8, National 10, National 11 and National 12). These cards were analyzed to determine if their performance in terms of rankings was consistent between the 2004 and 2005 surveys. It does not appear that a high ranking on the various card features in the 2004 survey results was highly correlated with a high ranking in the 2005 survey results. One drug discount card, National 12, did perform well according to both survey, ranking within the top six on almost all topics in each survey. Two cards, National 5 and National 6, performed poorly according to both survey results, frequently ranking in the bottom five. The remaining seven cards sampled for both surveys showed no pattern over the course of the two surveys, with positive rankings in one survey's results not correlated with positive rankings in the other survey's results.

3.0 Enrollment and Switching: Analysis of Administrative Data

3.1 Issues

This section of the final report presents findings from analyses of trends and patterns in drug discount card enrollment and "switching" among cards. We addressed several questions in these analyses.

- What were the trends in Medicare drug card enrollment for the program as a whole?
- What were the trends in Medicare drug card enrollment for key beneficiary groups and for the major card types?
- How "uneven" was enrollment across cards? Were a few cards responsible for most of the enrollment?
- How did enrollees differ among national, regional, and exclusive card programs?
- How did Medicare drug card enrollees differ from non-enrollees?
- When and how frequently did enrollees switch Medicare drug cards?
- How did enrollees who switched drug cards differ from enrollees who did not switch?

3.2 Data and Methods

For the drug card enrollment and switching analyses, we used three sources of data: the Medicare enrollment database (the EDB file) for beneficiary identifying information, a drug card enrollment file supplied by CMS for detailed records of beneficiaries' drug card enrollment since May 2004, and the 2000 Census Bureau data for ZIP-code level Income measures.

We also chose a comparison group of 6.6 million Medicare beneficiaries (out of 38 million eligible for selection) to represent eligible persons who did not enroll in the Medicare Drug Discount Card program. To be included in the comparison sampling frame, individuals had to have been alive on August 1, 2005, and both continuously enrolled in Medicare Part A and B and never enrolled in the drug card program from May 1, 2004 through July 20, 2005.

3.3 Findings

3.3.1 What were the trends in Medicare drug card enrollment for the program as a whole?

From May 2004 through August 2005, the program enrolled 6.6 million Medicare beneficiaries. Of these, 1.9 million were approved for the $600 T.A. subsidy. During 2004, enrollment in the Medicare drug discount card program increased steadily, with two relatively well defined period of particularly rapid growth, one from May to June 2004 (when nearly half of all enrollees entered the program) and a second increase of about 1.1 million from October to November 2004. Enrollment continued to grow, at a slower rate, from December 2004 through August 2005.

Three special initiatives designed to increase enrollment were implemented during this period:

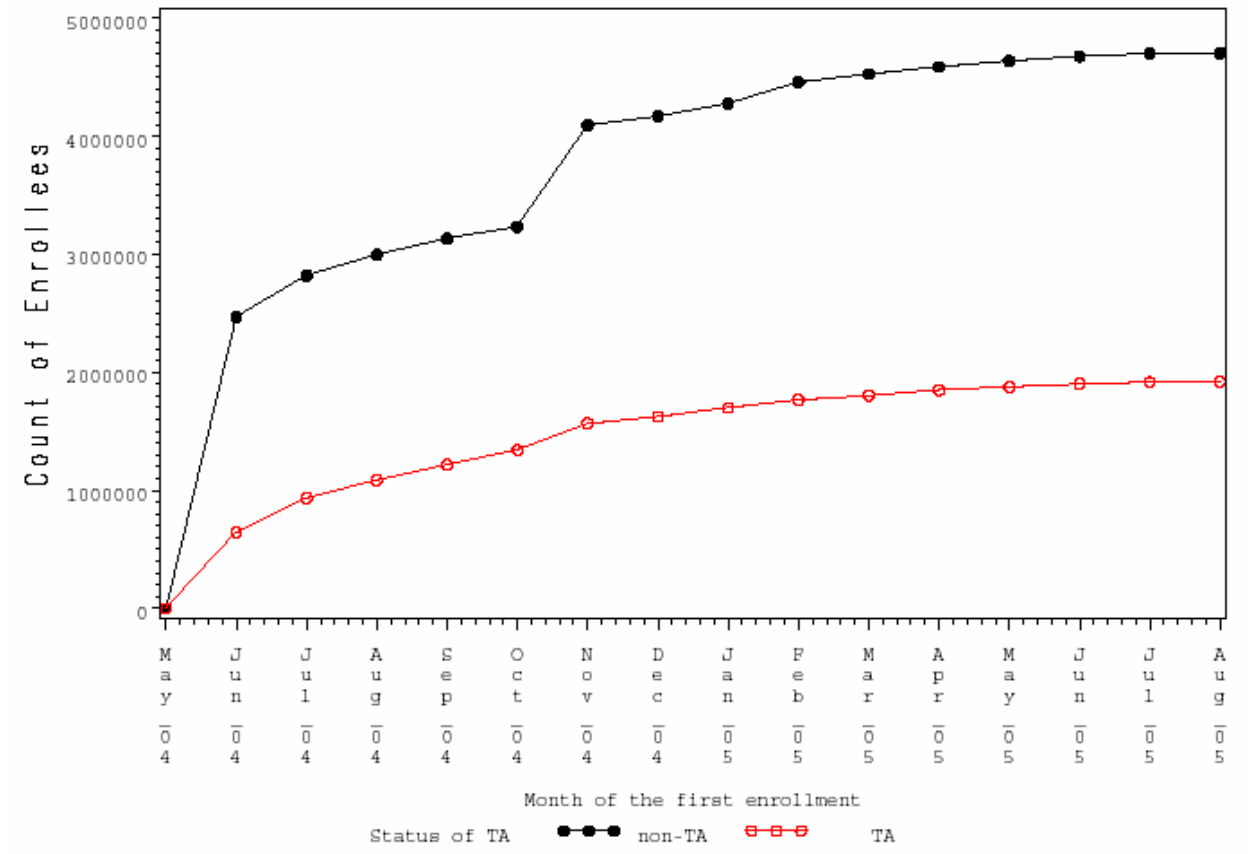
Group enrollment. When the card program began in May 2004, participating Medicare Advantage (MA) plans automatically issued exclusive cards to all their Medicare plan members. Much of immediate expansion in the program from May to June 2004 was driven by MA group enrollment.

Auto-enrollment. Many State Pharmacy Assistance Programs (SPAPs), with financial support from CMS, automatically enrolled their members in the Medicare drug card program. Many SPAP enrollees qualified for the T.A. subsidy. A steady increase of enrollment with T.A. from June through December 2004 probably reflected SPAP activities.

Facilitated enrollment. Early in the fall of 2004 (and in a second round early in 2005), CMS implemented Facilitated Enrollment Initiatives designed to increase the number of cardholders with T.A. approvals. The initial effort included a mailing to all 1.8 million low-Income beneficiaries eligible for the Medicare Savings Program, provision of additional outreach funds, simplification of the Medicare Compare website, and implementation of a telephone enrollment process for T.A. applicants. To activate the card and the $600 credit, the beneficiary had to call Medicare or the card sponsor. CMS implemented a second round of facilitated enrollment in February 2005. The October Initiative led to a one-time increase in enrollment of cardholders with and without T.A. from October to November 2004, and a more modest increase in February 2005.

The combined effects of these initiatives on T.A. and non-T.A. enrollment are shown in Exhibit 28. Both groups experienced two periods of accelerated growth at the same time, but both the absolute and relative increases were larger and more distinct for non-T.A. enrollees. In contrast, T.A. enrollment trends were more gradual, with less well-defined periods of acceleration or decline after June 2004.

Exhibit 28: Cumulative Medicare Drug Discount Card T.A. and Non-T.A. Enrollment: May 2004 – August 2005



Source: Abt Associates Inc. Medicare Drug Discount Card Enrollment/Switching File

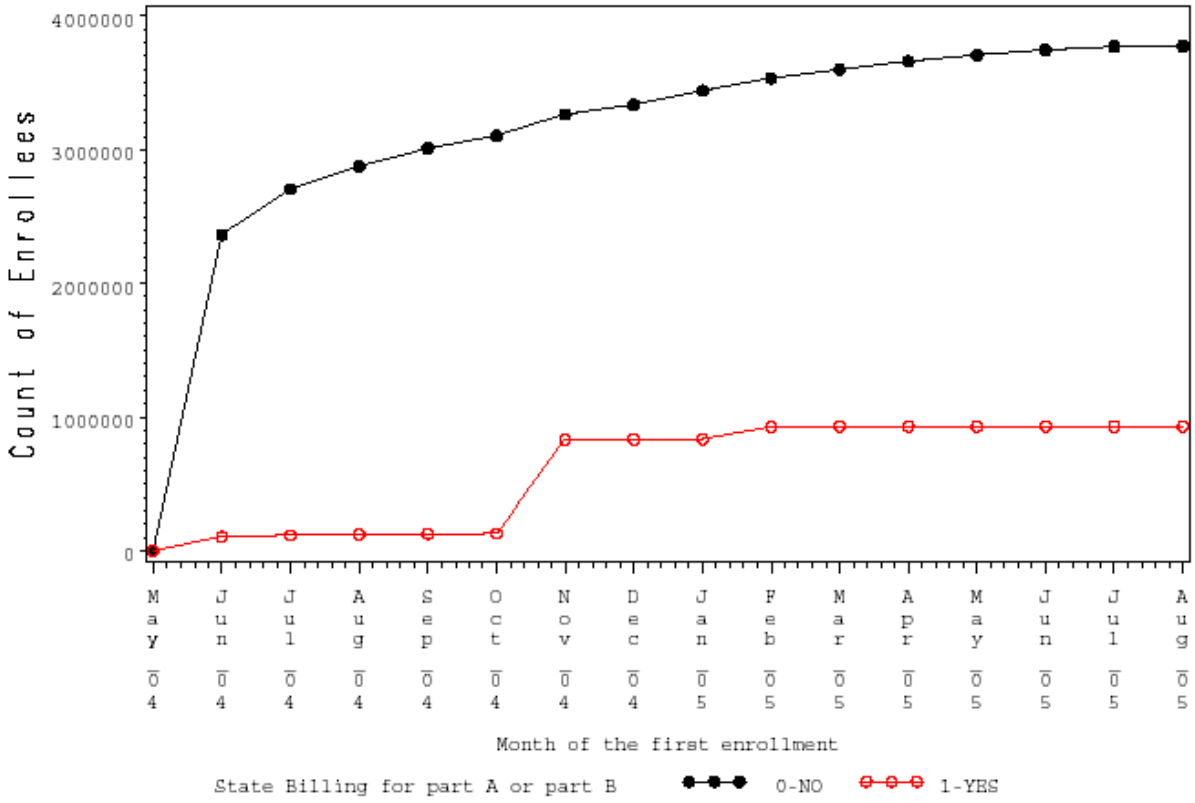
3.3.2 What were the trends in Medicare drug card enrollment for key beneficiary groups and for the major card types?

Early drug card enrollment growth was fueled by MA group enrollment efforts and by SPAP auto-enrollment of low-Income beneficiaries, many of who were eligible for T.A. But among several "target beneficiary groups" with a high probability of being T.A.-eligible, early enrollment growth was relatively slow. These groups included disabled beneficiaries, beneficiaries living in rural areas and areas with high prevalence of poverty, and beneficiaries who benefited from State buy-in programs. Following CMS's October Facilitated Enrollment Initiative, relatively large increases in enrollment were achieved among beneficiaries in all these groups. Despite the overall success of this

Initiative in attracting more T.A. and non-T.A. enrollees,[25] the larger enrollment increases from October to November were for beneficiaries who did not receive T.A.[26]

This pattern was true overall and for the "target" groups likely to include T.A.-eligible individuals. Exhibits 29 and 30 demonstrate this pattern for State buy-in beneficiaries, an important target group in efforts to increase T.A. participation. Buy-in beneficiaries were slow to enroll in the drug card program. In June, buy-in beneficiaries were 9 percent of all enrollees. After the October Facilitated Enrollment Initiative, State buy-in beneficiaries constituted 24 percent of all enrollees, after a one-time increase in enrollment of 163 percent, compared to a minimal six percent increase for other beneficiaries.

Exhibit 29: Cumulative Medicare Drug Discount Card Enrollment, Non-T.A. Enrollees, by State Buy-In; May 2004 – August 2005

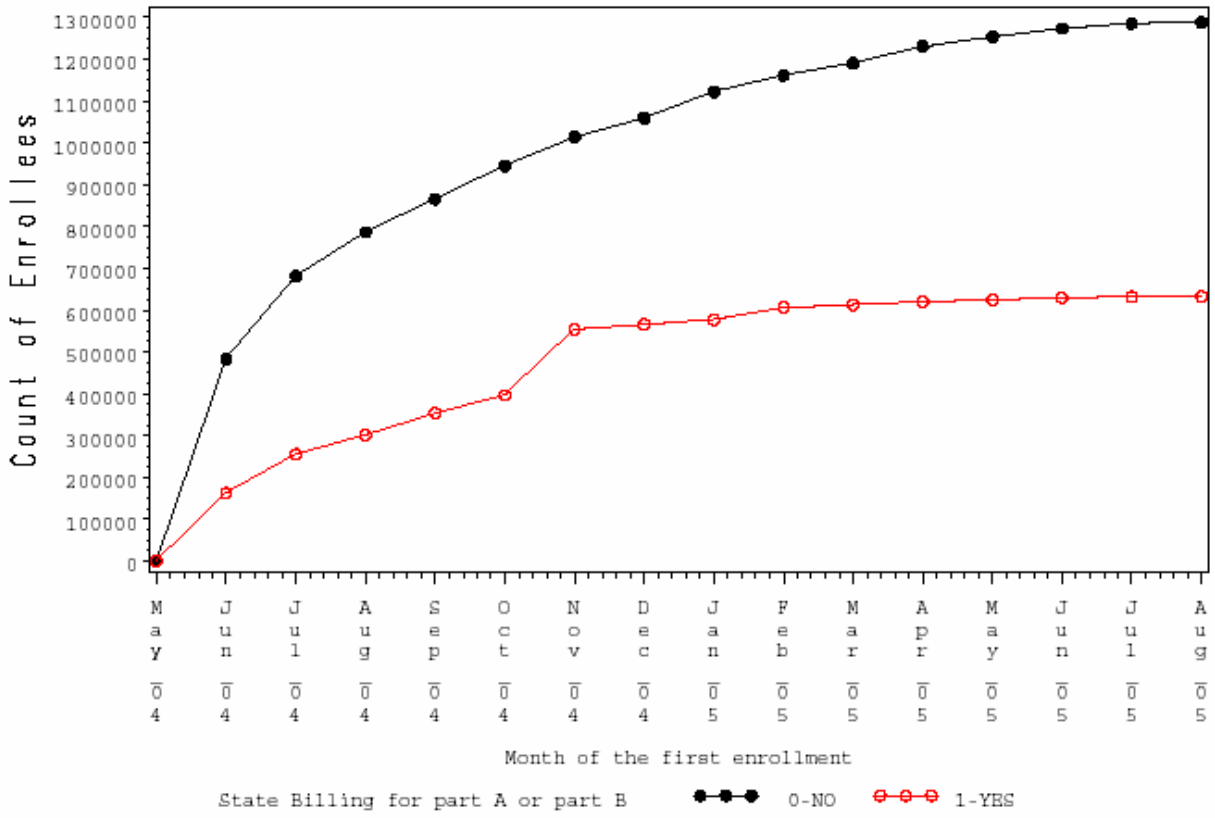


Source: Abt Associates Inc. Medicare Drug Discount Card Enrollment/Switching File

[25] In this section of this report, we use the term "T.A. enrollees" and "T.A. enrollment" to describe cardholders who have attested that they are eligible for T.A. and who have been approved for the T.A. subsidy. "Non-T.A. enrollees" and "non-T.A. enrollment" describe cardholders who do not receive a T.A. subsidy.

[26] T.A-eligible beneficiaries whose enrollment was facilitated by CMS did not receive the T.A. credit unless they activated it, and were therefore considered Non-T.A. enrollees.

Exhibit 30: Cumulative Medicare Drug Discount Card Enrollment, T.A. Enrollees, by State Buy-In; May 2004 – August 2005



Source: Abt Associates Inc. Medicare Drug Discount Card Enrollment/Switching File

T.A. enrollment among State buy-in beneficiaries followed a familiar pattern, increasing rapidly from May through October. After an initial increase to 157,000 from May to June, T.A. enrollment from this group grew 148 percent from June to October. In contrast, non-T.A. enrollment grew to 111,000 from May to June, and increased by only 23 percent from June to October.

Non-T.A. buy-in response to facilitated enrollment was dramatic, increasing 526 percent from October to November. The T.A. response was marked but smaller (35 percent increase). By the end of December, both groups had reached 89 percent of their total enrollment for the period.

3.3.3 How "uneven" was enrollment across cards – were a few cards responsible for most of the enrollment?

Enrollment volume varied greatly among drug cards and among the major programs card types, including national and regional cards available to Original Medicare beneficiaries and cards offered by MA plans to their enrollees (exclusive cards). Enrollment tended to be highly concentrated, particularly for national and regional cards, as Exhibit 31 shows. For example, the largest national card accounted for 10 percent of all national card enrollment.

Exhibit 31: Enrollment By Type of Card: Largest 10 Cards in Major Card Groups

Card Type/Card Number	Enrollment	Cumulative %[1]
National		
12	345,688	10.2%
51	328,001	19.9
5	297,576	28.7
48	275,034	36.8
11	247,888	44.2
6	244,937	51.4
43	197,515	57.2
10	144,369	61.5
8	141,347	65.7
4	122,762	69.3
Regional		
20	247,119	49.7%
3	128,796	75.6
19	24,267	80.5
4	17,153	84.0
30	16,490	87.3
1	14,780	90.2
2	10,480	92.4
5	6,236	93.6
10	4,772	94.6
8	3,714	95.3
Exclusive		
10	360,460	13.2%
20	239,625	21.9
76	181,104	28.6
75	134,381	33.5
2	103,255	37.2
12	100,624	40.9
81	91,090	44.3
62	82,555	47.3
93	64,154	49.6
7	58,417	51.8

[1] Cumulative percent within card type

Source: Abt Associates Inc. Medicare Drug Discount Card Enrollment/Switching File

3.3.4 How did enrollees differ among national, regional, and exclusive card programs?

Enrollee profiles varied among the three major card type in several respects. Compared to regional and exclusive cards, national card enrollees were 1) younger (relatively more under age 65), and therefore more likely to be disabled, 2) more likely to be non-white, 3) more likely to live in a non-urban area, in the South and in areas with high rates of poverty, 4) more likely to benefit from State buy-in programs (Exhibit 32).

Exhibit 32: Medicare Drug Discount Card Enrollees, By Card Type

Group	Values	National (n = 3,383,109)	Regional (n = 497,109)	Exclusive (N=2,735,555)
Age				
	<65	28.6	6.8	10.7
	65-74	35.4	39.0	46.0
	75-84	28.1	38.1	34.1
	85+	9.7	16.1	9.2
Age and Gender				
	Men <65	13.3	3.0	5.1
	Women <65	13.5	3.8	5.6
	Men 65+	23.6	25.6	37.2
	Women 65 +	49.6	67.6	52.1
Race				
	White	78.5	88.8	83.7
	Non-white	21.5	11.2	16.3
Urban Area				
	Urban	66.9	75.2	96.9
	Non-urban	33.0	24.7	3.0
	Missing	0.1	0.1	0.1
Census Region				
	Northeast	12.3	49.3	18.7
	Midwest	19.6	9.8	13.2
	South	52.0	39.8	28.9
	West	16.0	0.9	39.2
	Missing	0.4	0.1	0.1
Percent Below Poverty				
	<5%	9.2	13.1	17.7
	5-9%	22.5	27.3	31.6
	10-14%	21.9	24.4	20.2
	15%+	34.9	31.6	25.0
	Missing	11.5	3.7	5.5

Exhibit 32: Medicare Drug Discount Card Enrollees, By Card Type

Group	Values	National (n = 3,383,109)	Regional (n = 497,109)	Exclusive (N=2,735,555)
Entitlement Reason				
	Aged	74.9	94.9	92.3
	Disabled/ ESRD	24.7	5.1	7.7
	Missing	0.4	--	--
State Buy-In				
	State Buy-In	39.0	15.0	6.2
	No State Buy-In	61.0	85.0	93.8
Ever In MA				
	Yes	5.4	19.4	99.7
	No	94.6	80.6	0.3
T.A./Non-T.A.				
	T.A.	70.6	17.7	11.7
	Non-T.A.	43.4	3.6	53.0

Source: Abt Associates Inc. Medicare Drug Discount Card Enrollment/Switching File

3.3.5 How did Medicare drug card enrollees differ from non-enrollees?

Overall, Medicare drug card enrollees were somewhat more likely to be in the 75–84 year age group and to be non-white than non-enrollees. Within the enrollee group, however, enrollees with T.A. were both younger (under age 64) and older (85+ years) than enrollees without T.A., and even more likely to be non-white (Exhibit 33)

Compared to non-enrollees, enrollees were more likely to live in urban areas, in the South and West, and in areas with relatively high poverty levels. T.A. enrollees were twice as likely to live in non-urban areas as non-T.A. enrollees. T.A. enrollees were also more likely to live in the South and in high poverty areas than non-T.A. enrollees.

Exhibit 33: Medicare Drug Discount Card Enrollees, Compared to Non-Enrollees

Group	Values	Enrollees (n = 6,627,489)	Non-T.A. (n = 4,760,945)	T.A. (n = 1,866,544)	Non-enrollees (n = 6,627,489)
		(%)	(%)	(%)	(%)
Age					
	<65	18.6	17.8	20.9	21.4
	65-74	40.1	42.7	33.5	40.6
	75-84	31.3	30.8	32.5	27.7
	85+	10.0	8.7	13.1	10.3
Age and Gender					
	Men <65	9.1	9.0	9.4	11.3
	Women<65	9.5	8.8	11.5	10.1
	Men 65+	29.4	33.2	19.5	33.8
	Women 65+	52.0	49.0	59.6	44.8

Exhibit 33: Medicare Drug Discount Card Enrollees, Compared to Non-Enrollees

Group	Values	Enrollees (n = 6,627,489)	Non-T.A. (n = 4,760,945)	T.A. (n = 1,866,544)	Non-enrollees (n = 6,627,489)
Race					
	White	81.4	82.0	79.9	84.3
	Non-white	18.6	18.0	20.1	15.8
Urban Area					
	Urban	80.0	84.3	68.9	75.4
	Non-urban	20.0	15.6	31.0	23.6
	Missing	0.1	0.1	0.1	1.0
Census Region					
	Northeast	17.7	14.3	26.4	20.2
	Midwest	16.2	16.8	14.8	24.0
	South	41.5	38.7	48.6	34.6
	West	24.4	29.9	10.2	18.7
	Missing	0.3	0.3	0.1	0.3
Percent Below Poverty					
	<5%	13.0	14.9	8.2	14.9
	5-9%	26.6	28.4	22.1	26.8
	10-14%	21.4	21.0	22.3	19.7
	15+%	30.5	28.7	35.3	24.8
	Missing	8.4	7.0	12.2	13.9
Entitlement Reason					
	Aged	83.6	84.8	80.7	83.5
	Disabled/ESRD	16.2	15.0	19.3	16.1
	Missing	0.2	0.3	0.1	0.4
State Buy-in					
	Buy-in	23.6	20.1	32.5	13.3
	No Buy-in	76.4	79.9	67.5	86.7
Ever in MA					
	Yes	45.5	55.6	19.9	8.9
	No	54.5	44.4	80.1	91.1

Source: Abt Associates Medicare Drug Discount Card Enrollment/Switching File

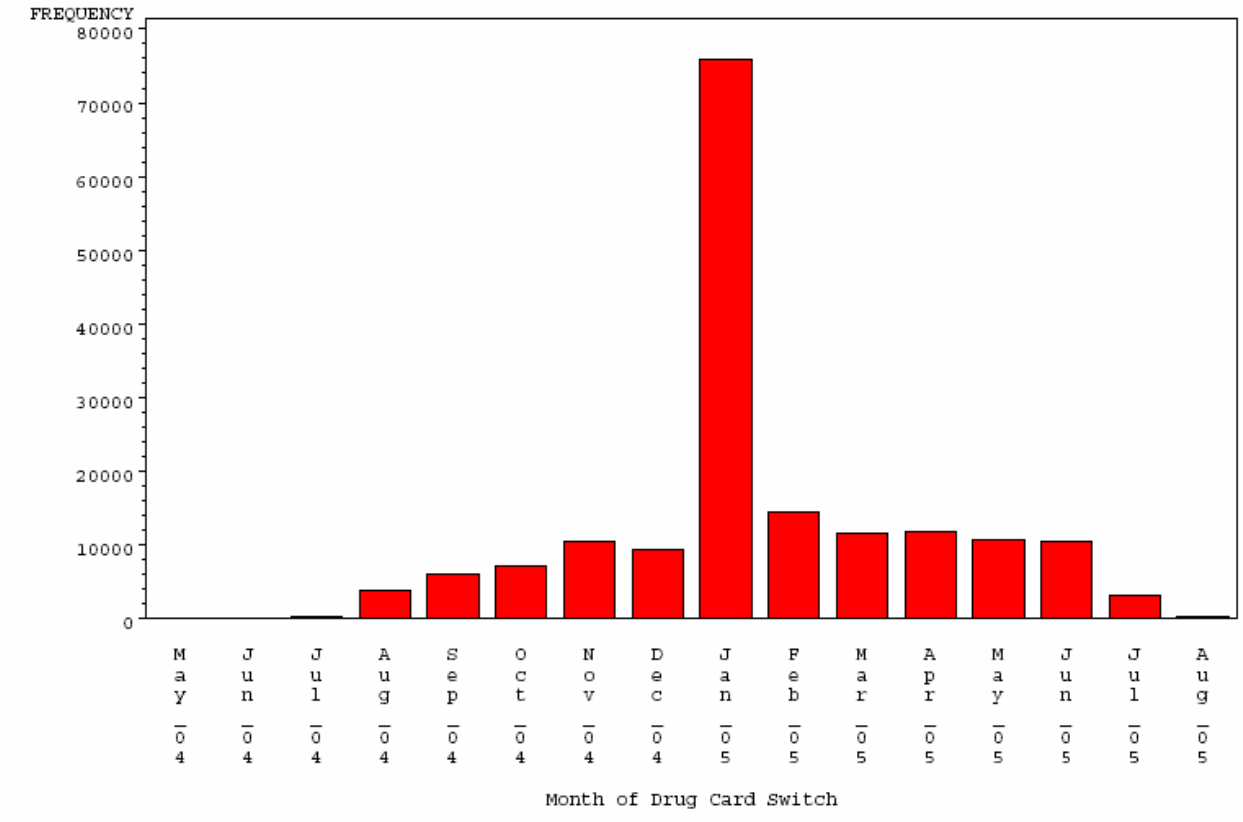
Although drug card enrollment was largely unrelated to reasons for entitlement, T.A. enrollees were somewhat more likely than non-T.A. enrollees to have been disabled. Enrollees were generally more likely than non-enrollees to be part of State buy-in programs, and T.A. enrollees were much more likely than non-T.A. enrollees to benefit from buy-in. Because MA plans enrolled a large number of plan members in exclusive cards, the proportion of all enrollees who were ever in an MA plan was larger than the MA proportion of non-enrollees. However, T.A. enrollees were much less likely to have been enrolled in MA plans than non-T.A. enrollees.

3.3.6 When and how frequently did enrollees switch Medicare drug cards?

Only 175,580 drug cardholders switched cards (2.7 percent of total enrollment), and only four percent of these switched more than once. Over 40 percent of decisions to switch were made between

November 15 and December 31, 2004 (the time set aside for unrestricted card switching). These decisions were implemented in January 2005, as Exhibit 34 shows.

Exhibit 34: Timing of First Drug Card Switch: May 2004 – August 2005



Source: Abt Associates Inc. Medicare Drug Discount Card Enrollment/Switching File

3.3.7 How did enrollees who switched drug cards differ from enrollees who did not?

On many measures, switchers were not greatly different from non-switchers(Exhibit 35). However, switchers were more likely to live in the South and were also more likely to have been in an MA plan. Within the switching group, there were differences between those who made their decisions during November/December 2004 and actually switched effective January 2005. "January switchers" were younger (more under age 65) and entitled by disability, were more likely to have been in State buy-in programs, and more likely to have been in Original Medicare than other switchers.

Exhibit 35: Medicare Drug Discount Card Switchers Compared to Non-Switchers

Group	Values	Non-switchers (N = 6,451,909)	Switchers (n = 175,580)	January Switch (n = 75,915)	Other Switch (n = 99,665)
Age					
	<65	18.7	18.2	21.4	15.8
	65-74	40.0	43.1	40.2	45.2
	75-84	31.3	30.7	30.0	31.1
	85+	10.0	8.1	8.4	7.9
Age and Gender					
	Men<65	9.2	7.9	9.5	6.7
	Women<65	9.5	10.3	11.9	9.1
	Men 65+	29.4	28.8	24.1	32.4
	Women 65 +	52.0	53.0	54.5	51.9
Race					
	White	81.5	78.4	79.8	77.4
	Non-white	18.5	21.6	20.2	22.6
Urban Area					
	Urban	80.0	82.8	68.7	93.3
	Non-urban	20.0	17.1	31.3	6.6
	Missing	0.1	0.1	0.1	0.1
Census Region					
	Northeast	18.0	7.2	6.8	7.6
	Midwest	16.3	13.1	15.7	11.3
	South	41.2	53.3	61.1	47.4
	West	24.3	26.2	16.4	33.6
	Missing	0.3	0.1	0.1	0.1
Percent Below Poverty					
	<5%	13.1	11.3	9.7	12.6
	5-9%	26.6	26.8	23.8	29.1
	10-14%	21.4	22.7	23.7	21.9
	15%+	30.4	34.4	37.5	32.1
	Missing	8.6	4.7	5.4	4.3
Entitlement Reason					
	Aged	83.6	83.6	79.7	86.5
	Disabled/ ESRD	16.1	16.4	20.2	13.5
	Missing	0.3	--	0.2	--
State Buy-In					
	State Buy-In	23.5	27.8	41.0	18.0
	No State Buy-In	76.5	72.2	59.0	82.0
Ever In MA					
	Yes	45.0	66.2	27.4	95.3
	No	55.0	33.8	72.6	4.7

Source: Abt Associates Inc. Medicare Drug Discount Card Enrollment/Switching File

Switching benefited exclusive cards (a net increase of about 21,000 cardholders), at the expense of regional cards (reduction of roughly 2,600) and national cards (reduction of about 18,500 cards). Switching also increased the numbers and percentage of T.A. enrollees (Exhibit 36). Twenty-four percent of switchers received the T.A. subsidy with their first card. This percentage nearly doubled for the second card, representing a net increase of over 34,000 cardholders with T.A. Among

switchers, those who changed from their original card and no T.A. to a new card and the T.A. subsidy were much more likely to be from groups targeted by SPAPs for auto-enrollment and by CMS in its facilitated enrollment initiative (disabled beneficiaries, residents of non-urban areas, areas of high poverty, benefiting from State buy-in programs). Switches involving MA exclusive cards generally resulted from enrollment in or disenrollment from MA plans. Therefore, the motives for most these switches were not likely to have been issues of drug card satisfaction, but rather issues with specific MA plans or managed care in general.

Exhibit 36: Medicare Drug Discount Card Switches: First to Second Card, by Card Type

First Card	Second Card			TOTAL
	National	Regional	Exclusive	
NATIONAL	53,626 (62.2%)	4,147 (4.8%)	28,386 (33.0%)	86,159
REGIONAL	3,818 (45.4%)	200 (2.4%)	4,389 (52.2%)	8,407
EXCLUSIVE	10,142 (12.5%)	1,438 (1.8%)	69,434 (85.7%)	81,014
TOTAL	**67,586**	**5,785**	**102,209**	**175,580**

Source: Abt Associates Medicare Inc. Drug Discount Card Enrollment/Switching File

3.4 Discussion

Over 18 months, Medicare enrolled 6.6 million drug discount cardholders (about 15 percent of 44 million[27] eligible beneficiaries). Most stayed with their first card. Fewer than four percent switched cards during this period. Perhaps a permanent discount card program would have attracted more enrollees over a longer period of time (and probably generated more switching activity as well). Nonetheless, in spite of early challenges and the time-limited nature of the program, CMS demonstrated that intensive, targeted efforts can yield success in recruiting program participants from parts of the Medicare beneficiary population that are often difficult to reach (disabled beneficiaries, non-white beneficiaries, beneficiaries whose States paid their Medicare cost-sharing amounts, and beneficiaries living in high-poverty areas). Ultimately, T.A. participation achievements were gained through the combined efforts of outreach from various CMS partners, auto-enrollment programs coordinated by State Pharmacy Assistance Programs and facilitated enrollment initiatives implemented by CMS in October 2004 and February 2005.

[27] Total Medicare beneficiaries continuously eligible for Medicare Parts A and B during the 18-month study period.

4.0 Lessons Learned for Monitoring Drug Card (and Future Drug Plan) Performance

A great deal of primary and secondary data were explored in this evaluation, some of which shows promise for ongoing performance monitoring, especially for future monitoring of Prescription Drug Plans under Part D. Beneficiary survey responses indicate customer satisfaction with services and benefits offered by drug discount cards, which in turn can serve as a means of comparing the performance of the cards (or their sponsors). Drug card enrollment and switching may reflect on the ability of drug discount cards to retain their enrollees. Neither of these data sources was specifically designed to measure performance of drug discount cards; they provide at best imperfect performance measures because they can be influenced by factors beyond the drug card sponsors' control and they reflect only narrowly defined aspects of performance.

This section of the report takes a first step toward developing performance measures based on extant data as well as new primary data collection. Ideally, performance monitoring should identify events that:

- can be observed, measured, or counted
- are influenced by the decisions and actions of drug card sponsors, and
- reflect aspects of the program that matter to beneficiaries.

Such events rarely have single causes, and therefore are sensitive to factors that may be irrelevant to program performance. And it is worth noting that in some paradoxical cases, the frequency of adverse events can be increased by improved performance. For example, the number of complaints about service is probably related to the number of service interactions. Programs with more customers, or more interactions per customer, may therefore show higher numbers of complaints even though their service is better.

To avoid such paradoxes, performance measures are generally constructed by adjusting the observed data to minimize or eliminate the effects of irrelevant sources of variation. For example, we generally recast the frequency of events as a rate per enrollee or per enrollee month. In some cases, other denominators may provide more informative rates. Ideally, such adjustments reflect an explicit model of the sources of variation in the observed data, but in real world situations, data and models are rarely complete so the adjustments aim to make the best possible use of available information.

The goal is to try to use existing data collection efforts that were designed for other purposes, to measure the performance of drug discount cards. Since these measures were not designed to be performance indicators, they cannot generally be externally validated. Moreover, data that we would like to be able to use for adjustment are incomplete. For example, among all the satisfaction measures explored in the survey, financial aspects of the drug discount program are overwhelmingly the most important determinants of satisfaction. The survey, however, provides only indirect information about beneficiaries' financial situations (rather than exact dollar amounts based on claims, for example), so adjustments are incomplete.

4.1.1 Potential Data Sources

Survey of Enrollees in Medicare Approved Drug Discount Cards

A total of nine items on the 2005 Survey of Medicare-Approved Drug Discount Card Enrollees (including overall satisfaction) are potentially related to performance. These are displayed in Exhibit 37. One of these (Item B3: switching from a previous card) is primarily a measure of dissatisfaction with the previous card. Since this card is not identified in the survey, this item is a very weak indicator of performance. Administrative data are a much better source of information on card switching, as discussed later.

Exhibit 37: Indicators of Satisfaction, by Transitional Assistance, 2005

Survey Question	Received Transitional Assistance (T.A.)	Others (Non-T.A.)
A1: Percent who report they have a card.	81%	43%
B2: Percent who would recommend to friends or family.[a]	96%	74%
B3: Percent reporting they did not switch.[a]	92%	92%
A8: Percent reporting use of card every time/most of the time.[a]	89%	72%
B4a: Percent very/somewhat satisfied overall.[a]	94%	63%
B4c: Percent very/somewhat satisfied with choice of pharmacies. [a]	95%	82%
B4d: Percent very/somewhat satisfied with amount of money saved [a]	92%	52%
C1: Percent reporting that they saved “a lot”. a	62%	15%
C2: Percent reporting that they saved “more than expected” a	48%	8%

[a] Excludes Non-respondents and Respondents who did not know the answers to questions.

Apart from this item, all the remaining eight are highly correlated with each other (Exhibit 38). The remainder of this section explores the relationship among several of these items to determine whether and how they can be used as performance measures.

Exhibit 38: Correlations Among Survey-Based Performance Indicators, 2005

	Overall Satisfaction	Saved a lot	Saved a lot more than expected	Recommend to others	Amount Saved	Report they have a card	Use card every/most of the time	Choice of Pharmacy	Did not switch
Overall Satisfaction	1.00								
Saved a lot	0.93	1.00							
Saved a lot more than expected	0.86	0.91	1.00						
Recommend to others	0.90	0.81	0.69	1.00					
Amount Saved	0.75	0.70	0.68	0.61	1.00				
Report they have a card	-0.46	-0.52	-0.53	-0.39	-0.29	1.00			
Use card every/most of the time	0.32	0.16	0.03	0.45	0.27	0.49	1.00		
Choice of Pharmacy	0.24	0.15	0.21	0.26	0.47	0.51	0.51	1.00	1.00
Did not switch	0.10	0.05	0.01	0.07	0.09	0.31	0.56	0.13	

Source: Abt Associates Inc. Survey of Drug Discount Card Enrollees, 2005

Beneficiary satisfaction with the drug discount cards offered in 2004 through 2005 depended almost entirely on how satisfied they were with the amount of money they thought they were saving by using the cards (Exhibits 39 and 40). This single item explained 71 percent of the total variance in overall satisfaction.[28] Adding information about satisfaction with the choice of pharmacy and the enrollment process increased the explained variance by only three additional percentage points.[29]

Exhibit 39: Overall Satisfaction with Drug Card, by Satisfaction with Amount of Money Saved, 2005

Satisfaction with Amount Saved	Overall Satisfaction with Card					
	Very Satisfied	Satisfied	Neither	Dissatisfied	Very Dissatisfied	Total
Very Satisfied	92%	7%	1%	0%	0%	100%
Satisfied	25%	68%	4%	2%	1%	100%
Neither	7%	48%	41%	2%	1%	100%
Dissatisfied	3%	45%	22%	29%	1%	100%
Very Dissatisfied	3%	8%	12%	30%	47%	100%
Total	53%	27%	7%	7%	6%	100%

Source: Abt Associates Inc. Survey of Drug Discount Card Enrollees, 2005

Exhibit 40: Overall Satisfaction with Drug Card, by Perceived Amount of Money Saved, 2005

Overall, how much money do you think you have saved by using your card	Overall Satisfaction with Card					
	Very Satisfied	Satisfied	Neither	Dissatisfied	Very Dissatisfied	Total
A lot	90%	8%	1%	0%	0%	100%
Some	49%	42%	5%	4%	1%	100%
A little	9%	37%	19%	20%	13%	100%
None	3%	9%	9%	20%	59%	100%
Total	52%	27%	8%	7%	6%	100%

Source: Abt Associates Inc. Survey of Drug Discount Card Enrollees, 2005

Perceived savings reflect actual savings as filtered through the expectations of the beneficiaries. Actual savings were driven primarily by the transitional assistance given to the lowest-income beneficiaries. There are two ways to categorize T.A.: those who received it (based on administrative data) and those who were aware of having it (based on survey responses). For all reports on this project, including this one, respondents are categorized as having T.A. based on administrative data not self-reports, because the accuracy of the self-reports varied considerably.

[28] We estimated a simple regression of overall satisfaction (b4a) as predicted by satisfaction with amount saved (b4d) in this regression, $R^2 = 0.7106$

[29] We added the two other satisfaction measures, concerning the enrollment process (b4b) and choice of pharmacies (b4c) to the regression of savings (b4d). This raised R^2 to 0.7398

Three-quarters of surveyed beneficiaries who had T.A. were very satisfied with the amount of money they saved, compared with one quarter of those who did not have T.A. (Exhibit 41) while nearly 40 percent of those without T.A. who were dissatisfied with the savings they experienced.

Exhibit 41: Satisfaction with Amount Saved, by T.A. vs. Non-T.A., 2005

	Satisfaction with Amount Saved					
	Very Satisfied	Satisfied	Neither	Dissatisfied	Very Dissatisfied	Total
Received T.A.	76%	16%	3%	3%	3%	100%
Did Not Receive T.A.	23%	29%	8%	19%	20%	100%
Total	50%	23%	5%	11%	11%	100%

Source: Abt Associates Inc. Survey of Drug Discount Card Enrollees, 2005

Although the survey included an equal number of individuals with and without T.A. for each sampled drug discount card, some cards had more enrollees with T.A. than others. Since the T.A. effect constituted a real saving (up to $600 per year), and perceived savings were so important to satisfaction, drug cards enrolling the highest numbers of beneficiaries eligible for T.A. would be expected to have the most satisfied customers, regardless of their other qualities.

Overall, enrollees in the 17 national drug discount cards in our 2005 survey were somewhat more satisfied than those with either regional or exclusive cards (Exhibit 42). This was entirely due to the effect of T.A.; only seven percent of exclusive card enrollees had T.A., compared with about one third of national and regional card enrollees. Excluding those who had T.A, Exclusive card enrollees had the highest perceived satisfaction, with 39 percent describing themselves as very satisfied, compared with 28 percent of those in national cards, and only 19 percent of those in regional cards.

Exhibit 42: Overall Satisfaction, by type of card, for those with T.A., 2005

	Overall Satisfaction with Card					
	Very Satisfied	Satisfied	Neither	Dissatisfied	Very Dissatisfied	Total
All beneficiaries	52%	27%	8%	7%	6%	100%
Exclusive	45%	24%	13%	10%	8%	100%
National	54%	26%	7%	7%	6%	100%
Regional	40%	30%	11%	10%	8%	100%
Excluding those with T.A.	28%	35%	14%	13%	11%	100%
Exclusive	39%	25%	15%	11%	10%	100%
National	28%	36%	13%	13%	10%	100%
Regional	19%	37%	16%	15%	13%	100%

Source: Abt Associates Inc. Survey of Drug Discount Card Enrollees, 2005

Because transitional assistance is determined entirely by government regulation and beneficiary income, and not at all by drug discount card sponsors, its influence is completely unrelated to drug card performance. Beneficiaries who received T.A. may have used their cards differently, and experienced the effect of cards differently from others. Moreover, some drug discount cards may have had features that were more or less attractive to such beneficiaries (e.g., annual fee, formulary, level of discounts).

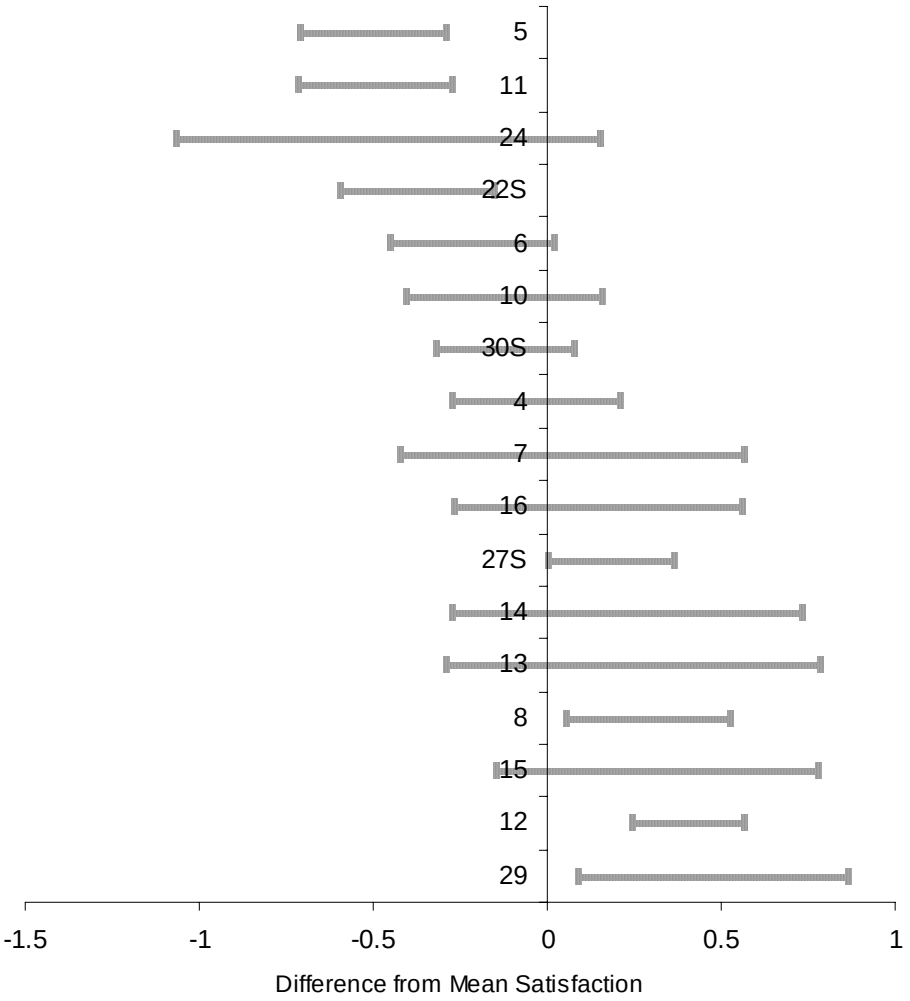
Because of the overwhelming dominance of T.A. as a determinant of satisfaction, we chose to control its effect by partitioning the data. Analysis of survey data was restricted to beneficiaries who did not receive T.A., on the assumption that their satisfaction is more reflective of drug card performance and less confounded with other effects. Data were also partitioned to compare exclusive cards only with other exclusive cards, and regional and national cards only with each other. In addition, regression models were used to reduce differences due to education, race, ethnicity, and age. These regressions were estimated using individual beneficiaries as the unit of analysis, and provide estimates of the effects of participation in each of the drug discount cards.

There was somewhat more variance among drug card plans than could be explained by chance alone, but satisfaction ratings for many drug discount cards could not be distinguished from average satisfaction levels. Exhibit 43 compares the 17 national drug discount cards represented in the 2005 survey. Each bar in the figure shows an estimate of the difference in mean satisfaction between enrollees in one drug discount card and the average of other cards. For example, enrollees in Drug Card National 5 (the top bar in the figure) expressed lower satisfaction than those with other national cards. Their mean overall satisfaction score was 0.5 points (on a five-point scale) lower than the average. Because this observed mean is based on a survey of a sample of respondents, rather than on the entire enrolled population, it probably is not the true mean that we would obtain if we canvassed 100 percent of card enrollees. Based on the characteristics of the survey, a 95 percent confidence interval for this difference is contained by the range 0.3 to 0.7 points. Because satisfaction is lower than average, the range is plotted on the left (negative) side of the figure. The remaining bars in the figure show the 95 percent confidence intervals for the mean satisfaction differences of the other national programs.

Three national cards (5, 11, and 22S[30]) appear to have enrollees who are on average less satisfied than those in other national cards. Three more (8, 12, and 29) have higher than average satisfaction levels. The individual 95 percent confidence internals are designed to have a false positive rate of five percent. Note that because the figure includes 17 comparisons, there is thus a good chance that one of these six is spurious. (We have no way of knowing which one.)

Exhibit 43: Satisfaction with Drug Discount Cards, 2005, National Cards

(excludes beneficiaries who received transitional assistance)



Source:Abt Associates Inc. Survey of Drug Discount Card Enrollees, 2005

Note: Figure shows 95% confidence intervals for mean satisfaction scores on a five point scale. Positive differences mean beneficiaries were more satisfied than the average of all National card enrollees responding to the survey. Confidence intervals that cross the axis indicate non-significant differences.

[30] The 'S' indicates a Special Endorsement card (intended for those in the territories, on Indian reservations, or in nursing homes); these cards each enrolled both special endorsement populations and general beneficiary groups, and we cannot determine which of their enrollees are in fact "special".

Enrollment data

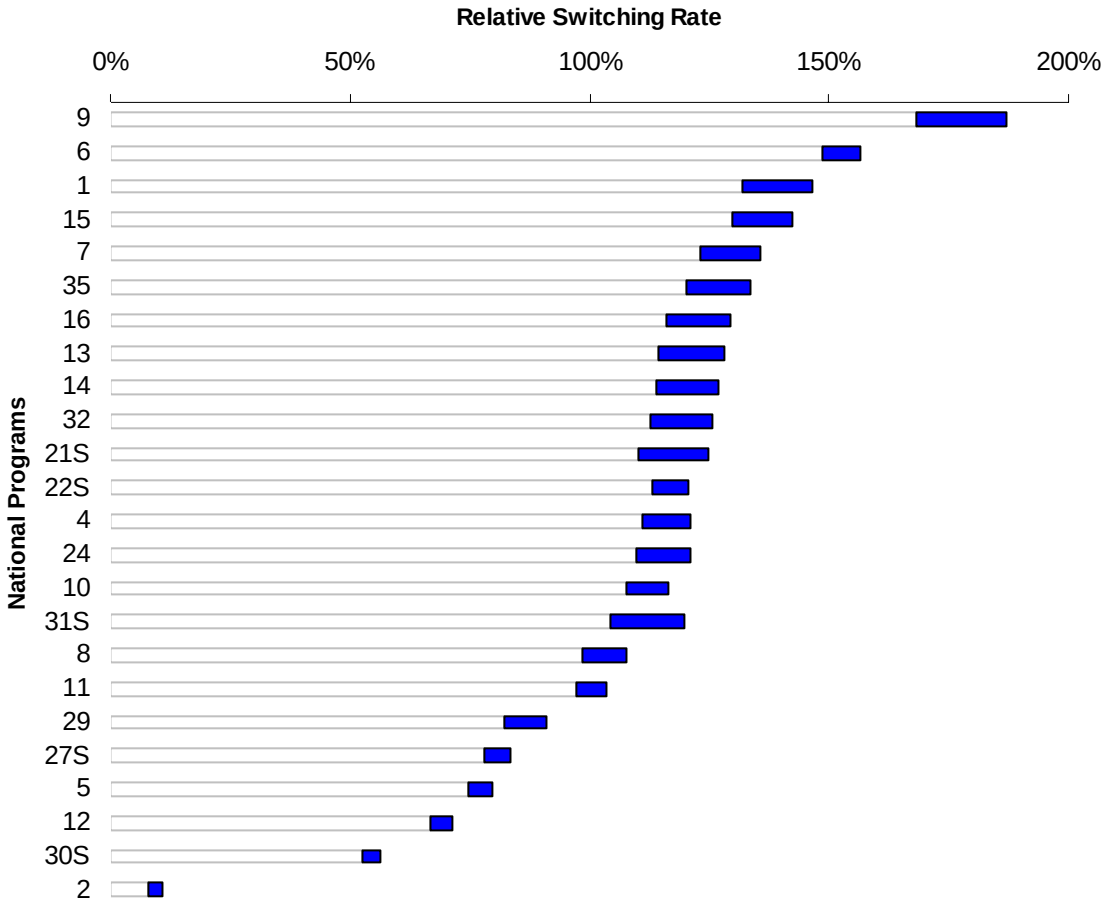
About one percent of beneficiaries who were enrolled in a drug discount card as of December 31, 2004 switched to a different card in January 2005. (Under some conditions, switches could occur at other times, but January was the only time that all programs allowed switches based solely on preference. The great majority of all switches occurred then.) Data were analyzed for 5.8 million beneficiaries who were enrolled in a drug discount program as of December 2004. Nearly 76,000 of these beneficiaries switched drug discount cards in the next month.

Data were statistically adjusted for sex, age, race and ethnicity urban or rural residence, and whether the beneficiaries received transitional assistance.

Exhibit 44 compares the national drug cards where we have sufficient data for analysis. (The program identifying numbers are the same as those used to describe the survey and grievance data. The survey included only selected drug cards, so the total set of drug cards is different in each analysis.) Each bar in Exhibit 44 compares the switching rate of one card with the average rate for all cards of similar type (exclusive, national, regional). Beneficiaries in national card 9 (the top bar in Exhibit 44) were about 77 percent more likely to switch than the average rate across all national cards. These data are based on a complete enumeration, rather than a survey, so this rate has no measurement error. However, as a measure of program quality, it is helpful to think of the beneficiaries making up the observed rate as a sample from a larger (essentially infinite) population of beneficiaries who might consider enrolling in drug cards. For national card 9, the 95% confidence interval for the rate under this assumption is 68 to 87 percent higher than average. This range is shown in the figure as 168 percent to 187 percent. Similar ranges are shown for each of the national drug discount cards.

About 58,000 (two percent) of the 2.8 million enrollees in national drug discount cards, switched in January 2005. Because this analysis is based on millions, rather than thousands, of cases, estimates are more precise than those from survey data. Sixteen of the 24 national cards had switching rates that exceeded the national average, and six had lower rates. (The remaining two could not be distinguished from average rates.) In absolute terms, however, most of the differences were small; only two exceeded the national rate by more than fifty percent, and only one had a rate that was more than fifty percent below the national average.

Exhibit 44: Departures from National Drug Discount Cards, January 2005



Source: Analysis of data from CMS enrollment data (EEVS)

Notes: Departure rates are expressed as odds ratios. A ratio of 100% means that the provider lost members at the average rate of all providers in the analysis. A ratio of 150% means the odds of leaving were 50% higher than the average. Bands show 95% confidence intervals.

4.1.2 Conclusions and Implications for Part D

Current data sources

Each of the data sources has strengths and limitations for purposes of measuring drug discount card performance. The survey of enrolled beneficiaries describes common events that reflect the experience of most enrollees. It provides rich detail, including some of the relevant background characteristics that affect customer satisfaction with the cards, such as education and disability status. Individual survey items provide some ability to distinguish different aspects of performance, such as financial effects, customer service, and pharmacy choices. However, expressed satisfaction appears largely dominated by perceived financial impact. While financial effect is certainly a key aspect of card performance, actuarial methods offer a more objective and precise assessment of financial impact than do respondents' ratings.

The primary value of the survey, and of future Part D surveys, is in measuring non-financial aspects of performance. To capitalize on this capability requires that the analysis control for financial effects so that beneficiaries with similar financial outcomes are being compared. In the test analysis reported here, such controls were imposed in two ways. The data were partitioned so that only beneficiaries without transitional assistance were being compared with each other (because T.A. was the overwhelming contributor to satisfaction), and a regression model was constructed that applied statistical adjustments for salient demographic variables such as race, ethnicity, education, and disability status. Other potentially relevant covariates, such as chronic health conditions and numbers of maintenance prescriptions, did not appear to improve the fit of these models, but a more detailed set of covariates might be more useful.

Given the primacy of economic impact, future surveys and analyses should incorporate as much detail as possible about the beneficiaries' financial situations. This might include administrative data such as claims against Part D benefits, as well as respondents' self-reports of prescription spending.

Data on beneficiaries who filed grievances or left their plans cover rare but highly salient events. Only one or two beneficiaries in a hundred switched drug discount cards, and only about one in a thousand filed a grievance. These data represent extreme negative reactions, which may bear little relationship to the experience of most enrollees. Moreover, because the data cannot readily be linked to beneficiary characteristics, statistical adjustment for differences in the client mix of different drug discount cards is limited.

Absolute vs. Relative Performance Measures

All the measures explored here compared individual drug discount cards with their peers. From the perspective of an informed consumer, this kind of comparison could improve decisions about which drug card (or Prescription Drug Plan) to choose from the available options. From a government regulatory perspective, these data do not indicate whether any of the cards/plans are outside the acceptable range of performance. This requires a value judgment about which aspects of performance should be regulated, and which should be left to market choice. Because all the readily available measures have limitations, they are more persuasive as a means of raising questions than of deciding them.

Aggregate vs. Disaggregated Performance Measures

Various measures of performance were highly correlated with each other and survey respondents who expressed high satisfaction with the financial aspects of their drug discount card experience also gave positive replies to other questions. We suggest, however, that CMS keep the detailed components of performance measures separate from one another, rather than aggregate them into a single index.

1. Disaggregated measures provide remedial guidance. Specifically described problems can be addressed with specific corrective action. Disaggregated data that are specific in time and cause (such as the grievance data) can provide early warning of problems that might be masked or obscured in aggregate data.

2. Some problems may be irrelevant to some beneficiary classes. Consumers should be able to evaluate their available options based on criteria that fit their health and economic situation and what they value most.

3. Excellent performance in one area should not hide failure in another, and vice versa.

Enhancing Data Collection

Of the nine possibly relevant items on the 2004 and 2005 surveys, one (switching to another card) is better measured by enrollment data, and another (awareness of having a card) is a very limited and indirect measure of performance). Three of the survey questions concern perceptions of cost saving. For the drug discount cards offered in 2004 and 2005, perceived cost savings depended almost entirely on whether beneficiaries received transitional assistance. Moreover, the question comparing perceived savings to expectations depends on the combined effect of three factors: actual savings, how these savings are perceived, and the accuracy of the beneficiary's knowledge of benefits.

This suggests two lines of modification for future surveys of Prescription Drug Plan enrollees. First, survey methodology is the only means of measuring non-monetary satisfaction. This strength can be exploited by adding specifically targeted questions about detailed aspects of the program. Second, in order to isolate economic effects, the survey could expand and collect more information about situational and health covariates so that similarly situated beneficiaries may be compared.

5.0 Implications for Part D

5.1 Awareness of the Program

Based on focus groups held in fall 2004 and winter 2005, the media and CMS channels were quite successful in ensuring that most beneficiaries quickly became aware of the Medicare drug discount card program. Some beneficiaries failed to enroll due to misperceptions about eligibility and likely savings. Some who were aware of the program did not realize that they had to take action to enroll, or how to do so (some were expecting a card, like their Medicare Part A&B card, to simply arrive in the mail). Others thought the program was for low-income beneficiaries only. These misperceptions and confusions underscore the importance of the key messages CMS is promoting to beneficiaries in 2005, in preparation for the Medicare drug coverage program (Part D), which include:

- Medicare prescription drug coverage is available to all people with Medicare.
- Additional help is available for those with limited income and assets.
- More information and assistance is available at 1-800-MEDICARE, medicare.gov, and local SHIPs.

5.2 Awareness of Enrollment

Two to thirteen months after enrolling (or being auto-enrolled) in Medicare-Approved Drug Discount Cards, 44 percent of survey respondents reported that they did not have a card or did not know if they had a card (although all did). Thirty-five percent of those in Non-Exclusive cards were unaware of their enrollment and 77 percent of those in Exclusive cards were unaware of their enrollment. Perhaps those in Exclusive (M.A.) cards believe that their discount cards are part of their M.A. "package" and do not realize that they are enrolled in both the M.A. plan and in the Exclusive drug discount card offered by that plan. In addition, most were probably enrolled in their M.A. plans' drug discount card as a group and did not fill out individual applications, again making their enrollment less obvious.

Among those enrolled in Non-Exclusive cards, 20 percent with T.A. (according to CMS administrative data) said that they did not receive the $600 credit or they did not know if they had received the credit. Among those enrolled in Exclusive cards, 36 percent with T.A. were unaware or unsure of having received the $600 credit (although all had).[31] It will be important that everyone enrolled in a Part D plan is aware of their enrollment; the fact that they will be paying monthly premiums may increase awareness of enrollment but may not entirely eliminate this problem. The T.A. respondents who were unaware that they had the T.A. credit were using their card less frequently than those who knew they had access to the credit. Confusion about T.A. may be affecting use of the card and its available benefits, and the same could occur among beneficiaries who apply for the extended low-income benefits under Part D but are confused about whether they qualified.

[31] Those in Exclusive cards may not realize that they in fact are receiving the $600 credit. Often M.A. plans reduced copayment requirements for those with T.A. (the subsidy was used to meet these copayments) but the individual only saw the reduced copays and didn't realize that this was because of the $600 credit.

Nearly half of card enrollees contacted during focus group recruiting in 2005 stated that they did not have a card. We believe the correct estimate is closer to 21 percent. Thirteen percent of those who had the T.A. credit (according to CMS administrative files) thought they did not have the $600 credit and another 17 percent were not sure. There seems to be some level of uncertainty among enrollees about their status, and some confusion among those with T.A. as to whether they do indeed have the $600 credit. It will be important that everyone enrolled in a Part D drug plan (or whomever is purchasing drugs on their behalf) is aware of their enrollment; the fact that they will be paying monthly premiums may increase awareness of enrollment but may not entirely eliminate this problem. Uncertainty about whether a T.A. application was approved raises concern that the same could occur among people who apply for the low-income subsidies under Part D and remain unsure about whether their application was approved.

Based on focus groups, it appears that uncertainty about enrollment and T.A. status were highest among those who were auto-enrolled (or whose enrollment was facilitated) by an SPAP, by their Medicare Advantage plan, or by CMS. Some portion of those who were auto-enrolled apparently did not understand (or may never have opened) the informational materials they received explaining their auto-enrollment. The same may occur when people are auto-enrolled into Part D drug coverage plans. Those who are deemed eligible and automatically enrolled may require more than a mailing from their Part D drug plan, in order to understand their enrollment and benefits and their options for switching if they are not satisfied with their drug plan.

Part D drug plans will need to be cognizant of this persistent problem of some people being unaware of their enrollment and not necessarily paying attention to mailed materials. The envelopes containing Part D drug plan mailings may need a more obvious external message, for example, drawing attention to the Medicare-related contents. Focus group participants reported that they were less likely to mailings from a known and trusted source such as the Social Security Administration, AARP or their insurance carriers. This suggests that over time, as beneficiaries become accustomed to their new drug plan sponsors, they may be more likely to recognize and open mailings.

5.3 Information and Choices

A large percentage of beneficiaries we surveyed and met in focus groups did not consider more than one Medicare-Approved Drug Discount Card, and many did not realize that there were multiple cards to choose from. Some of these people were auto-enrolled and did not understand that they could make alternative enrollment decisions, but most simply did not look beyond the first card they encountered, especially if it was recommended by their pharmacist. If all cards were essentially identical, this probably would not matter, but cards were not identical and beneficiaries may not have enrolled in the card best suited to their particular circumstances. If the same occurs under Part D and many beneficiaries do not compare options and make deliberate choices, the feature of the program – choice – that is intended to exert market pressure toward enhanced value, may not have an optimal effect. It will be important for beneficiaries to understand that they a) have choices and b) need to take action to enroll in an appropriate plan that meets their individual needs.

Even though many survey respondents did not consider more than one card, most felt that they had enough, or more than enough, information when enrolling in their Medicare-Approved Drug Discount Card. Some beneficiaries reported that they were not using their cards because the cards did not offer discounts on the drugs they take; they might have benefited by exploring other cards that possibly used different formularies.

Pharmacists played a critical role in providing information, encouraging enrollment, and helping people use their Medicare-Approved Drug Discount Cards. Pharmacists were the most cited source of information when survey respondents were considering drug cards, and were also a trusted source

respondents would turn to if they had problems with their drug cards. Focus group participants relied on pharmacists to figure out the best combination of their various discounts, cards and benefits for each prescription they filled. Given this key role, pharmacists will need to understand the Part D drug plan program and CMS is working to educate pharmacists.

Very few survey respondents mentioned Medicare counseling services (SHIPs or others) as an information source when they were considering drug discount cards (five percent in the 2005 survey).[32] Similarly, almost no focus group participants had contacted their local SHIP (or even recognized its name). At the same time, many focus group participants expressed strong preferences for receiving personally-tailored information from an unbiased source, one-on-one. They appear to want what the SHIPs have to offer, but very few are locating this resource. CMS is therefore highlighting SHIP resources and services in the 2005–2006 National Medicare Educational Program (NMEP). As the Part D enrollment period approaches, most beneficiaries will need to be reached through sources that they are more accustomed to using. The most often mentioned sources of information on the drug discount card program were pharmacists, media, AARP, and insurance companies and agents with whom beneficiaries had existing relationships (in addition to family and friends). Building on existing trusted relationships may be a useful strategy for reaching out to beneficiaries as the Medicare drug coverage program approaches.

Only a few focus group participants could describe important program features, and many survey respondents could not correctly answer questions about features of the Medicare drug discount card program. Failure to understand some programmatic features is probably of little practical importance, but for other features an incorrect understanding could have important implications. For example, many focus group non-enrollees were under the impression that the drug discount cards were only available to those with limited incomes. And 16 percent of survey respondents held the erroneous belief that having a Medicare-Approved Drug Discount Card meant not being able to have cards from other sorts of discount programs sponsored by drug companies, pharmacies, or others. These sorts of misunderstandings indicate a need not only for outreach concerning enrollment and general information about Part D, but also an ongoing need for detailed information and education so that beneficiaries are best able to coordinate their new drug plans with other sources of assistance as SPAPs or manufacturer assistance programs.

5.4 Enrollment

Most focus group participants who enrolled in a drug discount card felt that the enrollment process went smoothly; this was true for those who enrolled online, over the phone, or by mailing an application form. T.A. participants reported no difficulty with the application process, although a few experienced delays in getting approved for T.A. There were also reports, especially in 2004, of lengthy delays in actually receiving cards in the mail. Under Part D, beneficiaries are going to expect to be able to use their cards in the first month that they are paying premiums. It will be important for drug plan sponsors to minimize delays in getting cards (or other proof of coverage) into the hands of their enrollees. It will also be important for beneficiaries and pharmacists to understand that drug plan enrollees can begin receiving plan benefits in the month after they enroll, even if they have not yet received their new drug plan insurance card in the mail.

[32] It is possible that beneficiaries were receiving help from SHIP counselors, at a senior center, for example, without realizing that the counselor was SHIP affiliated.

5.5 Using Medicare-Approved Drug Discount Cards

Focus group participants reported that sometimes the lowest purchase price for a drug was not the price offered by a discount drug card sponsor, but a lower price available through some other means (drugstore senior discounts, manufacturer discounts, etc.)[33] Sometimes a retail club (Costco, Sam's Club) offered a lower price without the drug discount card than with it. Focus group participants were beginning to learn how to get the best price for each of their drugs, which sometimes meant *not* using their Medicare drug discount cards. Survey respondents with T.A. were far more likely to use their cards every time they filled prescriptions, probably because most had not yet exhausted the $600 credit at the time the survey was fielded. Similar patterns might be anticipated under Part D, with low-income beneficiaries receiving greater benefits and continuing to use their cards, while others discontinue use (particularly during coverage gaps) if their cards are not bringing the lowest possible price.

Some beneficiaries' shopping strategies, aimed at minimizing out-of-pocket costs for prescription drugs, may need to change under Part D, when tracking out-of-pocket spending for covered drugs will be important for people who might qualify for catastrophic coverage (i.e. those who will have a coverage gap and then additional drug costs beyond $5100 per year.). Under Part D, some beneficiaries may find lower prices during coverage gaps by going outside their drug plan network; if so, they will need to understand how to report any out-of-plan expenses to their drug plans, so that these expenses can be counted toward their TrOOP costs. This aspect of the Part D program is different from most drug insurance or discount programs with which beneficiaries (or their pharmacists) are familiar.

T.A. focus group participants wanted to be able to track their $600 credit and to know when it was about to run out. In 2004 and early 2005, pharmacists did not always provide information about the T.A. credit balance; some pharmacies' systems were able to print this information on sales receipts, but some pharmacists told beneficiaries that they could not provide this information.[34] Part D drug plan members are likely to want to track their benefits as well, to know for example, when they're about to reach a coverage gap and when it will end. Drug plans will be sending monthly notices to plan members who fill prescriptions, containing benefit information; it will be helpful if pharmacists also provide this information to beneficiaries at point of sale and inform them that this information is available from their drug plans.

5.6 Prescription Filling Practices

A small percentage of survey respondents had in the past purchased drugs via mail order; this is apparently not a common practice among Medicare beneficiaries who enrolled in drug discount cards and may not be common among those enrolling in Part D drug plans either. To the extent that drug plans intend to rely on mail order to achieve savings, this may meet with limited acceptance among beneficiaries, who will probably continue to fill prescriptions at their local pharmacies.

Nearly half of all survey respondents acknowledged that at some time in the past they had decided not to fill prescriptions due to cost concerns, and a somewhat smaller percentage had at times skipped doses or taken smaller doses, to stretch their medications. Fewer people reported these practices after

[33] A few focus group participants bought drugs from Canada or Mexico.

[34] All pharmacists should have been able to access this information from card sponsors, either electronically or by phone, and were required (per their contracts with card sponsors) to provide this information to card enrollees at point of sale, when asked.

receiving their Medicare-Approved Drug Discount Cards, at least for the few months immediately after they received their cards, especially among those with T.A. Focus group participants, especially those with the T.A. credit, similarly appreciated their new ability to purchase and take their medications properly. This indicates that there is real potential for enhancing appropriate use of prescription medications through reduced prices and subsidies, especially for lower income beneficiaries who did not previously have any drug coverage. With even greater benefits available under Part D, these patterns of improved use of prescribed drugs are likely to continue and even increase.

5.7 Satisfaction and Savings

In the 2005 survey, 68 percent of respondents were satisfied with their Medicare-Approved Drug Discount Cards overall (11 percent were dissatisfied), and 70 percent were satisfied with the pharmacies available at which they can use their cards (only three percent were dissatisfied). It appears that pharmacy networks are broad and accessible enough to satisfy a large majority of enrollees. If Part D plan sponsors are able to maintain these broad pharmacy networks, the majority of participants will have easy access to prescription drugs at several retail pharmacies.

Respondents who indicated that they had considered more than one drug discount card, were only a little more likely to be satisfied with their drug discount cards than were those who did not consider more than one card. Apparently engaging in the choice process made only a small difference in the satisfaction respondents felt with their cards. This may be true for Part D drug plans as well; beneficiaries who are auto-enrolled or who enroll in the first drug plan they learn about may be nearly as satisfied as those who consider multiple plans.

Satisfaction and dissatisfaction varied considerably across the individual drug discount cards, on all four satisfaction measures. Overall drug card satisfaction (defined as respondents who were somewhat or very satisfied) varied greatly by card, as did satisfaction with the enrollment process and with the pharmacies at which cards were accepted. The greatest range was for satisfaction with savings. The substantial variability in satisfaction, and especially satisfaction with savings, might be expected to continue under Part D, with various plans' enrollees experiencing differing levels of satisfaction.

In the 2005 survey, 56 percent of respondents reported that they had saved some or a lot of money using their cards and 49 percent saved as much or more than they had expected to save. Those with T.A. were the most enthusiastic about savings, again because most had probably not yet exhausted their annual $600 credit for 2005, and some may not have exhausted the credit in 2004 either. In addition, 38 percent of those in Non-exclusive cards without T.A. reported that they saved some or a lot of money using their cards, indicating that the discounted prices available through cards were also bringing savings to Non-Exclusive card enrollees who do not have the $600 credit. With Medicare prescription drug coverage, potential benefits for those who are not low-income will be greater, and for those with limited-incomes, greater yet (especially if they were previously uninsured); as a result, perceived savings are likely to rise even more.

5.8 Changes between 2004 and 2005 Surveys

There were remarkably few differences in the responses of Non-Exclusive card enrollees between the 2004 and 2005 surveys. The following few differences between the two surveys may indicate some

impact of the passage of time and additional experience with drug discount cards, which may be true over time with Part D as well.[35]

- Although the drug discount card program had been in effect for one year at the time of the second survey, the awareness of being enrolled among Non-Exclusive card enrollees declined between 2004 and 2005. Awareness of enrollment in Part D prescription drug plans may not be optimal and may not improve over time, especially for those who are auto-enrolled.

- Compared to 2004, there was a slight increase in the percent of Non-Exclusive card enrollees who considered more than one card before making a choice. Over time, awareness of choices in Part D could increase somewhat.

- There was a slight decrease in the number of respondents reporting having never used their drug card and a slight increase in the number of respondents reporting using their drug card every time they filled a prescription. Over time, people may similarly become more familiar with how to use their Part D benefits.

- In 2005, Non-Exclusive card enrollees reported higher overall satisfaction ratings than the comparable group in 2004. After an initial period of some confusion and uncertainty, satisfaction with Part D drug plans may also increase over time.

- Fewer problems using drug discount cards were reported in 2005. Compared to 2004, there was a dramatic reduction in the number of respondents reporting difficulty finding a pharmacy where they could use their drug discount card. The same may well be true with Part D; considerable early difficulty in understanding and using plans may dissipate over the first year.

- In 2005, more Non-Exclusive card enrollees reported saving money with the drug card than in 2004 and a higher rate of saving more money than they'd expected. Similarly, as beneficiaries become more accustomed to using their Part D prescription drug plans, more may realize savings beyond what they expected.

These few changes between the two surveys may reflect gains due to experience with the drug cards, among other factors. These two surveys indicate that early findings may not persist, as beneficiaries gain experience with a new program like the drug discount cards. The fact that there were so few changes over the course of six months, however, reflects the persistence of early findings for many measures included in these surveys.

5.9 Awareness of Changes Coming in 2006

Although a high percentage of focus group participants were aware that there soon will be changes in Medicare drug coverage, almost none had any information or understanding about the new program. This should improve as NMEP outreach and education increases, and CMS will continue to monitor beneficiary awareness and understanding during the prescription drug plan initial enrollment period of November 2005 through May 2006.

[35] The fact that the two samples were different and the surveys were slightly different, means that these changes could be due to other factors as well.

5.10 Enrollment and Switching Implications

Over 18 months, Medicare enrolled 6.6 million drug discount cardholders (about 15 percent of 44 million[36] eligible beneficiaries). Most stayed with their first card; fewer than four percent switched cards during this period. Perhaps a permanent discount card program would have attracted more enrollees over a longer period of time (and probably generated more switching activity as well). Part D is a very different program and switching may be prompted by factors not present in the drug discount card program; most notably PDP formularies.

Enrollment volume varied greatly among drug cards and among the major programs card types, including national and regional cards available to Original Medicare beneficiaries and cards offered by MA plans to their enrollees (exclusive cards). Enrollment tended to be highly concentrated, particularly for national and regional cards. For example, the largest national card accounted for 10 percent of all national card enrollment. The same may be true under Part D, with a small minority of plans being responsible for a majority of enrollees.

Overall, Medicare drug card enrollees were somewhat more likely to be in the 75-84 year age group and to be non-white than non-enrollees. Compared to non-enrollees, enrollees were more likely to live in urban areas, in the South and West, and in areas with relatively high poverty levels. T.A. enrollees were twice as likely to live in non-urban areas as non-T.A. enrollees. T.A. enrollees were also more likely to live in the South and in high poverty areas than non-T.A. enrollees.

An important aspect of both programs is the substantial assistance offered to beneficiaries with very limited incomes. Ultimately, T.A. participation in the drug discount card was achieved through the combined efforts of outreach from various CMS partners, auto-enrollment programs coordinated by State Pharmacy Assistance Programs and facilitated enrollment initiatives implemented by CMS in October 2004 and February 2005. The same will likely be true for Part D, with most of the limited-income (and dual-eligible) beneficiary population being enrolled through auto-enrollment and/or facilitated-enrollment mechanisms.

5.11 Implications for Part D Performance Monitoring

Current Data Sources

The survey of enrolled beneficiaries describes common events that reflect the experience of most enrollees. It provides rich detail, including some of the relevant background characteristics that affect customer satisfaction with the cards, such as education and disability status. Individual survey items provide some ability to distinguish different aspects of performance, such as financial effects, customer service, and pharmacy choices. However, expressed satisfaction appears largely dominated by perceived financial impact. While financial effect is certainly a key aspect of card performance, actuarial methods offer a more objective and precise assessment of financial impact than do respondents' ratings.

The primary value of the survey, and of future Part D surveys, is in measuring non-financial aspects of performance. To capitalize on this capability requires that the analysis control for financial effects so that beneficiaries with similar financial outcomes are being compared. In the test analysis reported here, such controls were imposed in two ways. The data were partitioned so that only beneficiaries without transitional assistance were being compared with each other (because T.A. was the

[36] Total Medicare beneficiaries continuously eligible for Medicare Parts A and B during the 18-month study period.

overwhelming contributor to satisfaction), and a regression model was constructed that applied statistical adjustments for salient demographic variables such as race, ethnicity, education, and disability status. Other potentially relevant covariates, such as chronic health conditions and numbers of maintenance prescriptions, did not appear to improve the fit of these models, but a more detailed set of covariates might be more useful.

Given the primacy of economic impact, future surveys and analyses should incorporate as much detail as possible about the beneficiaries' financial situations. This might include administrative data such as claims against Part D benefits, as well as respondents' self-reports of prescription spending.

Data on beneficiaries who filed grievances (reflected in HPMS data) or left their plans cover rare but highly salient events. Only one or two beneficiaries in a hundred switched drug discount cards, and only about one in a thousand filed a grievance. These data represent extreme negative reactions, which may bear little relationship to the experience of most enrollees. Moreover, because the data cannot readily be linked to beneficiary characteristics, statistical adjustment for differences in the client mix of different drug discount cards is limited.

Absolute vs. Relative Performance Measures

All the measures explored here compared individual drug discount cards with their peers. From the perspective of an informed consumer, this kind of comparison could improve decisions about which drug card (or Prescription Drug Plan) to choose from the available options. From a government regulatory perspective, these data do not indicate whether any of the cards/plans are outside the acceptable range of performance.

Aggregate vs. Disaggregated Performance Measures

Various measures of performance were highly correlated with each other and survey respondents who expressed high satisfaction with the financial aspects of their drug discount card experience also gave positive replies to other questions. We suggest, however, that CMS keep the detailed components of performance measures separate from one another, rather than aggregate them into a single index.

- Disaggregated measures provide remedial guidance. Specifically described problems can be addressed with specific corrective action. Disaggregated data that are specific in time and cause (such as the grievance data) can provide early warning of problems that might be masked or obscured in aggregate data.

- Some problems may be irrelevant to some beneficiary classes. Consumers should be able to evaluate their available options based on criteria that fit their health and economic situation and what they value most.

- Excellent performance in one area should not hide failure in another, and vice versa.

Enhancing Data Collection

Of the nine possibly relevant items on the 2004 and 2005 surveys, one (switching to another card) is better measured by enrollment data, and another (awareness of having a card) is a very limited and indirect measure of performance). Three of the survey questions concern perceptions of cost saving. For the drug discount cards offered in 2004 and 2005, perceived cost savings depended almost entirely on whether beneficiaries received transitional assistance. Moreover, the question comparing

perceived savings to expectations depends on the combined effect of three factors: actual savings, how these savings are perceived, and the accuracy of the beneficiary's knowledge of benefits.

This suggests two lines of modification for potential surveys of Prescription Drug Plan enrollees. First, survey methodology is the only means of measuring non-monetary satisfaction. This strength can be exploited by adding specifically targeted questions about detailed aspects of the program. Second, in order to isolate economic effects, the survey could expand and collect more information about situational and health covariates so that similarly situated beneficiaries may be compared.

Appendix A: The Medicare-Approved Drug Discount Card – Real Successes and Some Lessons Learned[37]

Overview

The Medicare-Approved Drug Discount Card program has met the challenge of providing significant savings on the cost of prescription drugs for millions of American seniors. The savings offered are real, beneficiaries report high levels of satisfaction with the program and the enrollment process, and the drugs offered through the program have remained stable. The drug card program has offered substantial value to Medicare beneficiaries in terms of dollar savings. We also believe it has assisted millions of beneficiaries, particularly those currently without prescription drug insurance, learn more about comparing prices, the role of formularies, the potential benefits of generic medicines and lower cost alternatives, and the balance between enrollment fees and drug prices and other program features.

The program was designed as a stop-gap measure, providing assistance to Medicare beneficiaries for the 19 months prior to implementation of the Medicare drug benefit on January 1, 2006. Over 6.3 million seniors are getting significant discounts on their medicines – and over 1.8 million of these individuals are also getting $600 in 2004 and 2005 toward the purchase of their prescription drugs, and often qualify for special manufacturer discounts in addition to the Medicare discount and $600. Most drug card enrollees are satisfied with their drug card savings, and beneficiaries with limited incomes had even higher approval ratings of the drug card program. The evaluation also found that beneficiaries were especially satisfied with the choice of pharmacies at which they could use their cards and with the enrollment process.

Medicare-Approved Drug Discount Card Program Highlights

- **Discounts of 12 to 21 percent on common brand name drugs**. CMS analysis of Medicare-Approved Drug Discount Cards shows beneficiaries can obtain discounted prices that are about 12 to 21 percent less than the national average prices actually paid by Americans for commonly used brand-name drugs at retail pharmacies.

- **Limited-income beneficiaries can save 44 to 92 percent**. Limited-income beneficiaries can save much more, almost 44 to 92 percent over national average retail pharmacy prices, when using the Medicare-Approved Drug Discount Card with the best prices and the $600 in transitional assistance. Also, many limited-income beneficiaries can get significant special manufacturer discounts once the $600 credit is exhausted. There are over 1.8 million drug card enrollees with transitional assistance. Beneficiaries receiving $600 in transitional assistance were the most enthusiastic about drug card savings.

- **Substantial savings on generic drugs**. Beneficiaries currently using generic drugs can also obtain large savings using a Medicare drug discount card, saving 45 to 75 percent below typical prices paid by Americans for commonly used generic drugs. Beneficiaries currently

[37] Appendix A is a document created by CMS that further describes how lessons learned from operating the Medicare Prescription Drug Discount Card have been applied by CMS toward implementation of the Part D drug benefit.

using brand name drugs who are able to switch to generics can achieve even greater savings of 46 to 92 percent. These results underscore the potential for savings when individuals who are able to switch to generic medications do so.

- **Savings confirmed by independent analyses**. The Lewin Group, American Enterprise Institute and Kaiser Family Foundation have conducted studies confirming savings through use of the Medicare-Approved Drug Discount Card. Savings were found in the same range as or even higher than CMS analyses**.** With varying methodologies, Lewin found a discount of more than 20 percent, Kaiser found 8 to 61 percent savings depending on the specific drug, card program and pharmacy location and AEI found limited-income seniors can save half to three quarters of drug costs compared to other private alternatives.

- **Stable formularies**. CMS designed the drug card program to produce consistent savings and consistent availability of drugs over time for enrollees. A CMS analysis shows Medicare drug discount cards' formularies have remained very stable since the program was implemented. All card sponsors provided discounts on the top 100 drugs most commonly used by the Medicare population, and those drugs have been retained on the formularies since the program was implemented.

The Medicare-Approved Drug Discount Card program successfully achieved prescription drug savings so that people with Medicare no longer have to pay among the highest prices for prescription drugs. CMS has applied relevant lessons learned from administration of the drug card program in implementing the Part D benefit. The following section summarizes the highlights of major lessons learned from the drug card experience.

Highlights of Lessons Learned

The Medicare-Approved Prescription Drug Discount Card program was created as a stop-gap measure, especially aimed at Medicare beneficiaries with limited incomes, in order to provide relief on the cost of prescription drugs until the Medicare Part D drug benefit begins. With hindsight and expert internal and external evaluation, CMS has been able to apply relevant lessons learned from operating the drug card toward implementation of Part D.

It is worth noting that, in many respects, the CMS experience with the drug card program reinforced the direction the agency had planned to take with respect to implementation of Part D. For example, while marketing and outreach for the drug card focused on national efforts and messages, the focus for Part D has been regional and local. Given the differences in scope and potential impact on beneficiaries of the drug card versus Part D, sometimes CMS' plans for communication or beneficiary outreach were different for Part D, yet informed by our experience under the drug card. Aside from its very positive value for beneficiaries, the drug card has informed CMS on important aspects of the Part D benefit.

Finally, the points presented here represent highlights of the learning opportunities for CMS. There are many more lessons that may or may not be of interest to a general audience. Overall, the drug card experience was a valuable learning curve for CMS and for the many organizations which will offer, or assist in offering, Part D benefits.

The following lessons learned are derived from an internal CMS information collection process involving CMS Central Office and Regional Office staff as well as sponsors, contractors, and other external partners affiliated with the drug card program (212 individuals total). In addition, CMS has learned much from the work of the Government Accountability Office (GAO), Department of Health

and Human Services Office of Inspector General (OIG) and other independent studies, some of which are ongoing.

- **Beneficiary communications should be simple, carefully keyed to the target audiences, timely and adapted to local conditions and insurance options.** When possible, face-to-face training workshops and webcasts are most effective. The five target audiences identified for Part D are: Medicare Advantage enrollees, retirees with drug coverage, people with Medicaid, other limited-income individuals, and the remaining general population. CMS is conducting targeted outreach with national, regional and community-based outreach efforts as well as with all sister agencies at HHS and federal agencies that directly contact people with Medicare to promote awareness of the new prescription drug benefit at the grassroots level. The outreach strategy for Part D will include a broad array of organizations that have direct contact with beneficiaries, including local affiliates of national partner organizations, local extensions of some federal agencies, and the Aging Network.

- **Pharmacists play a key role in educating beneficiaries.** Beneficiaries cite pharmacists as the most frequently used source of information to learn more about the drug card program. Pharmacists played a key role in helping Medicare beneficiaries understand the program, enroll in drug cards, and use their drug cards. Within parameters, Part D Marketing Guidelines encourage health care providers (e.g., pharmacists, physicians, etc.) to take an active role in educating and providing beneficiaries with information regarding options available under Part D. In addition, CMS is supplying information and resources to pharmacists and providers through an extensive outreach campaign starting in the summer of 2005.

- **The U.S. Territories present special issues related to beneficiary outreach.** The Territories are a unique circumstance under both the drug card and Part D. A special team has been assigned to work on outreach to the territories for Part D to maximize understanding of the benefit and ways to access it.

- **Grassroots education efforts should start early.** Efforts are well underway to have community-level organizations recruited, trained, and ready to assist beneficiaries as soon as beneficiaries start receiving marketing material from Part D plans. In additional, Regional Offices are extending their partnerships and collaborating with the Aging Network to ensure a sufficient network is in place to assist beneficiaries with enrollment issues and other questions.

- **Ensure Medicare beneficiaries with low-incomes realize the benefits of choosing or being auto-enrolled in a Part D plan.** One of the most commonly cited best-practices relative to the drug card was allowing State Prescription Assistance Programs and Medicare Savings Programs (MSPs) beneficiaries to be auto-enrolled into the drug card and transitional assistance. Under the Medicare prescription drug benefit, CMS is implementing a similar strategy for people who qualify for extra help with their Medicare prescription drug coverage costs. CMS will help beneficiaries such as those in MSPs, those who receive SSI benefits, and others who apply and qualify for extra help, learn about their choices and join a Medicare drug plan on their own. However, if they do not choose a plan, CMS will auto-enroll the lowest income beneficiaries in a plan effective January 1, 2006, consistent with the statute. These beneficiaries will also have a special election period where they can change plans any time.

- **Coordinate CMS communication and outreach plan with sponsors' communication and outreach plans.** CMS is proactively communicating with sponsors regarding Part D outreach messages and resources through the CMS website at http://www.cms.hhs.gov/partnerships/, frequent User Group calls, and the Health Plan Management System (HPMS).

- **The drug card outreach campaign highlighted the critical role of direct assistance in enrollment.** CMS is building an extensive grassroots outreach campaign for Part D that utilizes community based organizations' experience to tailor messaging and support to the needs of specific populations. CMS welcomes and will facilitate plan sponsors to actively support this important and challenging task.

- **Implement clear guidance, with public comment, on drug benefit marketing such that sponsors have the opportunity to devise clear, effective marketing materials from the start of the program and within budget.** CMS has sponsored Part D Marketing Materials Guidelines Training and has addressed all known policy issues. The review process has been streamlined by the expansion of the File & Use program. Contracted Part D sponsors can forego a prospective review of certain categories of marketing materials. CMS has contracted with BearingPoint to develop Part D marketing guidelines and the review process of PDP marketing materials to help assure consistency in marketing reviews. This contractor's experience with the Medicare-Approved Discount Drug Card program will provide valuable knowledge and skills to improve the Part D marketing materials review process. CMS has developed additional model materials that will further simplify the review process if they are used without modification.

Appendix B: Survey Sampling and Methods

Sample Selection

The target population for the surveys was all Medicare beneficiaries who were enrolled in a Medicare-Approved Drug Discount Card at least a few months before the survey was fielded to allow them time to receive and begin using their card. The 2004 survey was fielded in September-November 2004 and the 2005 survey was fielded in April–June 2005. The survey sampling frame therefore included beneficiaries who enrolled within the first six to eight weeks after the cards became available; these were beneficiaries who might be considered 'early adopters'.

The names and addresses of beneficiaries enrolled in various Medicare-Approved Drug Discount Cards were retrieved from the Enrollment, Eligibility, and Verification System (EEVS) along with dates of card enrollment and the specific card each beneficiary enrolled in. Enrollees in national and regional cards were eligible for both surveys, while those enrolled in exclusive (Medicare Advantage) drug cards were eligible for the 2005 survey only. In addition, enrollees whose reason for Medicare entitlement (Original Entitlement Reason) or whose Medicare status included ESRD, were removed from the sampling frame because their renal drugs are covered under Part B and their other drug use patterns are likely to differ dramatically from those of non-ESRD beneficiaries. Finally, those who had effective card enrollment dates after July, 2004, were removed from the 2004 sample and those who had effective card enrollment dates after January, 2005, were removed from the 2005 sample since they would not have had enough experience using the discount cards at the time of the survey.

The sample selection was done in two stages for each of the two surveys. At the first stage, a non-random sample of 27 drug discount cards was selected per survey.[38] Most of the largest national cards were included among the 27 selected for each survey sample. Some cards were selected for both surveys because they were among the largest in the nation at both time periods.[39] Furthermore, a geographic balance was sought among the 27 cards selected for each survey. Of the 27 cards selected for the 2005 survey, four were Exclusive cards offered by Medicare Advantage plans to their members, and the remainders were Non-Exclusive cards. A few regional cards with the requisite number of enrollees were also included in each sample so that the surveys would have some representation of beneficiaries who chose regional rather than national cards.

The second stage required selection of independent samples of 600 T.A. and 600 non-T.A. drug discount card enrollees, from each of the 27 drug discount cards. Only cards with at least this enrollment of 1,200 were eligible for the survey. Each of the two strata (T.A. and non-T.A.) was further stratified into two substrata: disabled and not disabled (aged). The sample of 600 non-T.A. enrollees was first allocated to each of the two substrata in proportion to the number of enrollees in the population in each of these two substratum. Then, a systematic random sample was selected in each substratum after sorting the enrollees by age group, gender and race/ethnicity. The same was done for the sample of 600 T.A. enrollees from each drug discount card.

The number of cards that had the requisite 1200 enrollees was less than 27 for the 2004 sample. To arrive at the total of 27 cards we therefore had to divide some of the largest cards into separate populations. In Exhibit B-1, there are three national cards with four regions each. These three national cards have a total sample of 4,800 (1,200 x 4 = 4,800) instead of 1,200. These three were the

[38] The number of cards to be sampled was based on budget considerations.

[39] National drug cards 4, 5, 6, 7, 8, 10, 11 and 12 were included in both surveys, as were Regional drug cards 3 and 4.

national cards with the highest enrollment; their populations were divided into the four census regions and samples were then drawn from each as if it was a discrete national card.[40] The distribution of the population and sample by strata and substrata for each of the 27 selected drug card programs sampled for the 2004 survey is shown in Exhibit B-1.

The distribution of the population and sample by strata and substrata for each of the 27 selected drug card programs sampled for the 2005 survey is shown in Exhibit B-2. The drug cards are numbered according to their National, Regional and Exclusive categories. Some numbers appear to be missing because we sequentially numbered every drug card for a variety of related analyses, but not every card was selected for the 2005 survey. For example, National cards 1–3 were not selected for the 2005 survey. A few cards have a suffix of "S"; these are national cards whose sponsors also have a Special Endorsement card and it is not possible to distinguish the two (the "D" numbers CMS assigned were the same for the national card and the Special Endorsement card offered by the same sponsor). It is possible that some of beneficiaries with these cards were Special Endorsement enrollees (living in nursing homes, on Indian reservations or in U.S. territories) but we cannot identify these individuals for analytic purposes. We do know that none of the survey respondents lived in the territories, but some may have resided on Indian reservations or in nursing homes.

Enrollment in the 27 selected cards for the 2004 survey represents 72.5 percent of all card enrollees who met eligibility criteria for the survey (not ESRD, not exclusive or special endorsement cards, not Medicaid, with card enrollment effective dates before July 2004). Our selected sample of 32,434 represents 3.1 percent of all eligible card enrollees, across all cards.[41] Enrollment in the 27 selected cards for the 2005 survey represents 58.7 percent of all card enrollees who met eligibility criteria for the survey (not ESRD, with card enrollment effective dates before February 2005). Our selected sample of 32,400 represents 0.6 percent of all eligible card enrollees, across all cards.

[40] In addition, one card that had different enrollment fees in different states, had a total sample of 2,400 divided between 'High' and 'Low' annual enrollment fee.

[41] One drug discount card had a total of 634 in one of its two strata, and all 634 were retained, so the final survey sample for the 2004 survey was 32,434.

Exhibit B-1: Survey Sample by Drug Card, 2004 Survey

Card	SAMPLE				
	T.A. - Disabled	T.A. - Aged	Non-T.A. - Disabled	No-T.A. - Aged	Total Sampled
Regional – 1	77	523	61	539	1,200
Regional – 2	162	438	78	522	1,200
Regional – 3	134	466	75	525	1,200
Regional – 4A Low	50	550	36	564	1,200
Regional – 4B High	65	535	37	563	1,200
Regional – 5	165	435	70	530	1,200
National – 1	266	368	150	450	1,234
National – 2	167	433	36	564	1,200
National – 3	242	358	127	473	1,200
National – 4	173	427	74	526	1,200
National – 5	127	473	49	551	1,200
National – 6	250	350	197	403	1,200
National – 7	230	370	57	543	1,200
National – 8	242	358	127	473	1,200
National – 9	132	468	72	528	1,200
National – 10 Region 1	182	418	73	527	1,200
National – 10 Region 2	120	480	60	540	1,200
National – 10 Region 3	169	431	81	519	1,200
National – 10 Region 4	138	462	67	533	1,200
National – 11 Region 1	301	299	114	486	1,200
National – 11 Region 2	145	455	83	517	1,200
National – 11 Region 3	204	396	124	476	1,200
National – 11 Region 4	179	421	104	496	1,200
National – 12 Region 1	255	345	127	473	1,200
National – 12 Region 2	115	485	84	516	1,200
National – 12 Region 3	182	418	125	475	1,200
National – 12 Region 4	145	455	103	497	1,200

Exhibit B-2: Survey Sample by Drug Card, 2005 Survey

	SAMPLE				
	T.A. Disabled	T.A. Aged	Non-T.A. Disabled	Non-T.A. Aged	Total in Sample
Regional 3	90	510	44	556	1,200
Regional 4	26	574	11	589	1,200
Regional 10	51	549	25	575	1,200
Regional 19	11	589	2	598	1,200
Regional 29	50	550	107	493	1,200
Regional 30	57	543	68	532	1,200
National 4	160	440	200	400	1,200
National 5	69	531	17	583	1,200
National 6	186	414	115	485	1,200
National 7	204	396	220	380	1,200
National 8	188	412	208	392	1,200
National 10	131	469	176	424	1,200
National 11	140	460	128	472	1,200
National 12	111	489	94	506	1,200
National 13	256	344	227	373	1,200
National 14	265	335	249	351	1,200
National 15	126	474	241	359	1,200
National 16	245	355	230	370	1,200
National 22S	111	489	93	507	1,200
National 24	152	448	221	379	1,200
National 27S	145	455	98	502	1,200
National 29	90	510	225	375	1,200
National 30S	75	525	113	487	1,200
Exclusive 10	36	564	26	574	1,200
Exclusive 20	82	518	55	545	1,200
Exclusive 44	68	532	40	560	1,200
Exclusive 75	29	571	26	574	1,200

Survey Methods

Questionnaire

The surveys were produced in booklet form. The 2004 and 2005 surveys were 14 and 11 pages long, respectively, including the cover and an instruction page. They showed the standard Medicare Approved Rx logo on Page 1, to orient respondents. The same survey was sent to both T.A. and non-T.A. drug discount card enrollees. The two surveys were very similar, with a few questions added, removed or amended in the 2005 survey based on lessons from the first survey. The questions that had a high rate of missing answers were evaluated and in some cases changed for the second survey. The second survey was further amended to include more skip patterns.

The surveys included questions in the following domains:

- Reasons for choosing a card and sources of information used when making this decision
- Use of the card and reasons for not using it all the time, including other sources of insurance or assistance that help pay for prescription drugs
- Applying for, and being approved for, T.A., and problems using T.A.
- Satisfaction with Medicare-drug discount card features and plans to continue with same card
- Problems using cards and where to turn for help, as well as satisfaction with customer service offered by drug discount card sponsors
- Expectations for savings and whether actual savings were more/less than expected
- Changes in prescription filling practices and skipping/decreasing doses to reduce costs
- Knowledge of drug card programmatic features
- Current insurance, current health status, demographics

Survey Implementation

The beneficiary surveys were conducted by mail. A survey ID number was created for each of the beneficiaries in the sample files; these ID numbers were linked to name and mailing address to create the survey mailing list. The surveys were conducted following a modified "Dillman approach",[42] with a 12-week field period from first mailing to final receipt of returned questionnaires. A toll free help-line was staffed by bilingual interviewers to answer any questions respondents had about the surveys and to send a Spanish-language version of the questionnaire if requested. If respondents called the help-line and stated that they had no Medicare-Approved Drug Discount Card, or had not yet used their card, but refused to mail back the questionnaire, this minimal information was collected along with the survey ID number, and entered into the study database.

A cover letter from CMS was enclosed in the first mailing (envelope customized with CMS logo). Each mailing included the questionnaire, a toll-free number to phone with any questions, and the offer of a Spanish version of the questionnaire, upon request.

- First mailing of the questionnaire with full cover letter

[42] Dr. Dillman suggests several rounds of mailings with cover letters followed by reminder postcards, to achieve the highest possible response rate. *Mail and Internet Surveys*, D. Dillman, 2000, Wiley, New York.

- Follow-up post-card one week later
- Second mailing of questionnaire, with abbreviated cover letter, three weeks after first mailing
- Follow-up post-card one week later
- Third mailing of questionnaire, with abbreviated cover letter, six weeks after first mailing
- Follow-up post-card one week later
- Fourth mailing of questionnaire, sent Priority Express, ten weeks after first mailing
- Follow-up post-card one week later

As questionnaires were returned they were logged in, checked for legibility and 'cleaned' to force skip patterns and back-code open-ended answers. All questionnaire data were entered twice and the two files compared for 100 percent verification; any discrepancies were resolved by survey staff. CMS Administrative data (card number, T.A. or not, age, eligibility (aged vs. disabled), etc.) were appended to each record, and then names, addresses and HIC numbers were removed from the file to protect respondent anonymity.

Survey Response Rates

2004 Survey Response Rates

Out of the 32,434 enrollees sampled for the 2004 survey, 23,985 returned a survey with at least the first question answered ("Do you have a Medicare-Approved Drug Discount Card?") (Exhibit B-3). In addition, 654 enrollees didn't return the survey but instead phoned or sent a note to tell us that they either had no drug card (490 respondents) or indicated that they had a card but had not yet used it (164 respondents). We asked these 654 respondents to mail back a survey indicating this information, but these two categories of respondents did not.

CMS is interested in knowing the percentage of beneficiaries who are unaware that they are enrolled in a card; regardless of whether respondents answer this important question by phone or by mail, their responses are valid. Therefore, the survey response rate includes those who didn't mail back the survey but did phone or send a note to answer the first question. With these responses included as completes, the total number of respondents was 24,639 and the survey response rate was 76 percent.

The survey analyses in this report use the entire set of completes, including those who provided minimal information by phone or a note, rather than by filling out the survey and mailing it back. This "analysis population" totals 24,639 respondents; a response rate of 76 percent.

Exhibit B-3: Survey Respondents, 2004 Survey

	Total	T.A.	Non-T.A.
Returned Completed Surveys	23,985	12,194	11,791
Phone Response: Have not yet used card	164	63	101
Phone Response: Do not have card	490	200	290
TOTAL RESPONSE	24,639	12,457	12,182

Source: 2004 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Fall 2004

Response rates varied among the different Medicare-Approved Drug Discount Cards sampled, as shown in Exhibit B-4, ranging from 51 percent to 82 percent. National cards as a group did not differ significantly from regional cards in their response rates.

Exhibit B-4: Response Rate by Card, 2004 Survey

	Responses Per Card		T.A. Enrollee Responses		Non-T.A. Enrollee Responses		Aged Enrollee Responses		Disabled Enrollee Responses	
Card	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Regional 1	877	73.1%	464	52.9%	413	47.0%	779	88.8%	98	11.1%
Regional 2	779	64.9%	427	54.8%	352	45.1%	623	79.9%	156	20.0%
Regional 3	921	76.8%	456	49.5%	465	50.4%	764	82.9%	157	17.0%
Regional 4 – high & low	1,946	81.1%	1,006	51.6%	940	48.3%	1,797	92.3%	149	7.6%
Regional 5	920	76.7%	465	50.5%	455	49.4%	740	80.4%	180	19.5%
National 1	880	73.3%	491	55.7%	389	44.2%	577	65.5%	303	34.4%
National 2	613	51.1%	287	46.8%	326	53.1%	520	84.8%	93	15.1%
National 3	930	77.5%	469	50.4%	461	49.5%	658	70.7%	272	29.2%
National 4	937	78.1%	475	50.6%	462	49.3%	736	78.5%	201	21.4%
National 5	824	68.7%	381	46.2%	443	53.7%	715	86.7%	109	13.2%
National 6	818	68.2%	436	53.3%	382	46.6%	515	62.9%	303	37.0%
National 7	948	79.0%	476	50.2%	472	49.7%	727	76.6%	221	23.3%
National 8	957	79.8%	481	50.2%	476	49.7%	676	70.6%	281	29.3%
National 9	920	76.7%	455	49.4%	465	50.5%	772	83.9%	148	16.0%
National 10 – all 4 regions	3,790	79.0%	1,896	50.0%	1,894	49.9%	3,085	81.3%	705	18.6%
National 11 – all 4 regions	3,662	76.3%	1,856	50.6%	1,806	49.3%	2,741	74.8%	921	25.1%
National 12 – all 4 regions	3,917	81.6%	1,936	49.4%	1,981	50.5%	3,010	76.8%	907	23.1%
Total	24,639		12,457		12,182		19,435		5,204	
Card Type (Regional/National)										
Regional	5,443	75.6%	2,818	51.7%	2,625	48.2%	4,703	86.4%	740	13.5%
National	19,196	76.1%	9,639	50.2%	9,557	49.7%	14,732	76.7%	4,464	23.2%

2005 Survey Response Rates

Of the 32,400 enrollees sampled for the 2005 survey, 22,021 returned a survey with at least the first question answered ("Do you have a Medicare-Approved Drug Discount Card?") (Exhibit B-5). In addition, 298 enrollees didn't return the survey but instead phoned or sent a note to tell us that they either had no drug card (258 respondents) or indicated that they had a card but had not yet used it (40 respondents). We asked these 298 respondents to mail back a survey indicating this information, but these two categories of respondents did not. With these responses included as completes, the total number of respondents was 22,319 and the survey response rate was 69 percent.

The survey analyses in this report use the entire set of completes, including those who provided minimal information by phone or a note, rather than by filling out the survey and mailing it back. This "analysis population" totals 22,319 respondents; a response rate of 69 percent.

Exhibit B-5: Survey Respondents, 2005 Survey

	All Respondents	Non-Exclusive			Exclusive		
		Total	T.A.	Non-T.A.	Total	T.A.	Non-T.A.
Returned Completed Surveys	22,021	18,925	10,405	8,520	3,096	1,696	1,400
Phone Response: Have not yet used card	40	33	14	19	7	3	4
Phone Response: Do Not Have Card	258	196	68	128	62	29	33
TOTAL RESPONSE	22,319	19,154	10,487	8,667	3,165	1,728	1,437

Source: 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Summer 2005

Response rates varied among the different Medicare-Approved Drug Discount Cards sampled for the 2005 survey, as shown in Exhibit B-6, ranging from 57 percent to 81 percent. Exclusive cards as a group had the lowest response rate with 66 percent, followed closely by National cards at 67 percent. Regional cards as a group had the highest response rate at 77 percent.

Exhibit B-6: Response Rate by Card, 2005 Survey

	Responses Per Card		T.A. Enrollee Responses		Non T.A. Enrollee Responses		Aged Enrollee Responses		Disabled Enrollee Responses	
Card	N	%	N	%	N	%	N	%	N	%
Exclusive 1	762	63.5%	415	69.2%	347	57.8%	720	63.3%	42	67.5%
Exclusive 2	724	60.3%	417	69.5%	307	51.2%	654	61.5%	70	51.3%
Exclusive 3	872	72.7%	479	79.8%	393	65.5%	794	72.7%	78	72.5%
Exclusive 4	807	67.3%	417	69.5%	390	65.0%	770	67.2%	37	67.9%
National 4	794	66.2%	457	76.2%	337	56.2%	562	66.9%	232	64.4%
National 5	889	74.1%	425	70.8%	464	77.3%	832	74.7%	57	65.6%
National 6	897	74.8%	478	79.7%	419	69.8%	664	73.9%	233	77.4%
National 7	682	56.8%	402	67.0%	280	46.7%	449	57.9%	233	54.9%
National 8	780	65.0%	474	79.0%	306	51.0%	535	66.6%	245	61.8%
National 10	797	66.4%	458	76.3%	339	56.5%	610	68.3%	187	60.8%
National 11	867	72.3%	466	77.7%	401	66.8%	683	73.3%	184	68.5%
National 12	943	78.6%	483	80.5%	460	76.7%	801	80.5%	142	69.5%
National 13	743	61.9%	448	74.7%	295	49.2%	435	60.7%	308	63.8%
National 14	728	60.7%	448	74.7%	280	46.7%	420	61.2%	308	60.0%
National 15	744	62.0%	479	79.8%	265	44.2%	541	65.0%	203	55.3%
National 16	753	62.8%	452	75.3%	301	50.2%	448	61.7%	305	64.3%
National 22S	870	72.5%	467	77.8%	403	67.2%	730	73.4%	140	68.3%
National 24	731	60.9%	441	73.5%	290	48.3%	512	61.9%	219	58.8%
National 27S	845	70.4%	434	72.3%	411	68.5%	677	70.7%	168	69.3%
National 29	696	58.0%	419	69.8%	277	46.2%	522	59.0%	174	55.2%
National 30S	848	70.7%	448	74.7%	400	66.7%	727	71.8%	121	64.5%
Regional 3	923	76.9%	458	76.3%	465	77.5%	812	76.2%	111	82.7%
Regional 4	954	79.5%	473	78.8%	481	80.2%	929	79.8%	25	68.8%
Regional 10	899	74.9%	444	74.0%	455	75.8%	845	75.2%	54	71.0%
Regional 19	966	80.5%	514	85.7%	452	75.3%	954	80.4%	12	88.7%
Regional 29	874	72.8%	421	70.2%	453	75.5%	770	73.8%	104	66.4%
Regional 30	931	77.6%	498	83.0%	433	72.2%	828	77.0%	103	82.4%
Exclusive	***3,165***	***65.9%***	***1,728***	***72.0%***	***1,437***	***59.9%***	***2,938***	***66.2%***	***227***	***62.9%***
National	***13,607***	***66.7%***	***7,679***	***75.3%***	***5,928***	***58.1%***	***10,148***	***68.2%***	***3,459***	***62.8%***
Regional	***5,547***	***77.0%***	***2,808***	***78.0%***	***2,739***	***76.1%***	***5,138***	***77.2%***	***409***	***75.5%***
Total	***22,319***	***68.9%***	***12,215***	***75.4%***	***10,104***	***62.4%***	***18,224***	***70.1%***	***4,095***	***63.9%***

Source: 2005 Survey on Medicare-Approved Drug Discount Cards, Abt Associates Inc., Summer 2005

Proxy Respondents

The survey could be completed by a proxy if the actual drug discount card enrollee was unable to do so; four percent of all responses to the 2004 survey and six percent of all responses to the 2005 survey were completed by proxy. In all survey analyses, proxy respondents and beneficiary respondents were combined.

Adjusting for Non-Response and Post-Weighting to Reflect Card Size and Composition

For producing population-based estimates, each respondent in the sample was assigned a sampling weight. This weight combines a base sampling weight which is the inverse of the probability of selection of the respondent, and an adjustment for non-response to account for those who did not respond to the survey. The base weight assigned was in accordance with the sampling procedure used for the selection of the sample. A sample of 1,200 persons was selected from the population in each of the 27 cards. The population of persons using a card was stratified into two categories of cards: T.A. and Non-T.A. A sample of 600 persons was selected from each of the two strata. For the selection of 600 persons from the T.A. stratum, we further stratified the population of persons into T.A. disabled and T.A. aged. The sample of 600 was allocated in proportion to the population in each of the two substrata. A similar allocation of 600 persons was done for the Non-T.A. stratum. In summary, there were 108 strata created for sample selection for each of the surveys.

The base weight assigned to a sampled person in a stratum is simply the number of persons in the population in the stratum divided by the number selected in the sample. Therefore, a person selected in a stratum that has a very large population will have a much larger weight than a person selected from a stratum with a smaller population. In other words, the base sampling weights reflect the fact that some cards are very large and some are small.

The weights were also adjusted for non-response (which varied by card and stratum within card) such that the sum of the respondent weights equal the total population in each stratum. As Exhibit B-3 and Exhibit B-4 (above) indicate, there were several hundred card enrollees who did not complete a survey either by mail or by phoning in the answer to the first question. Survey non-respondents were classified as ineligible (the sampled person had died and therefore could not respond), non-response (refusals), or unknown (the survey was not returned despite repeated mailings). The eligibility percentage of those whom we did reach was applied to the 'unknowns' as an estimate for how many of the unknowns would likely have been eligible, had we been able to reach them. This may be an over-estimate since the fact that we didn't reach these people may be related to their ineligibility (institutionalized or deceased). This is, however, the best assumption we can make about the eligibility rate for those we could not reach. To adjust the data, the proportion of ineligible to non-response was calculated and applied to the unknown category. Finally, a non-response adjustment was calculated for each stratum by dividing respondents by the sum of respondents and non-respondents, omitting ineligibles.

The calculated weights, adjusted for non-response, were used for all tabulations in the report.

Appendix C: Focus Group Methodology

Sampling

Two rounds of focus groups were conducted, the first in September–October 2004 and the second in February-March 2005.

Focus groups were conducted with two major types of beneficiaries: (1) Medicare beneficiaries who were enrolled in the Medicare-Approved Prescription Drug Discount Card and Transitional Assistance (T.A.) Program in fifteen specified counties,[43] and (2) Medicare beneficiaries in those same counties who were not enrolled in the drug card program or T.A. Information about drug card enrollment came from CMS' EEVS data system.

The target population for these focus groups was all Medicare beneficiaries in a total of fifteen specified counties. The sampling frame containing the names, addresses, and drug card program enrollment status of Medicare beneficiaries was provided by the Centers for Medicare and Medicaid Services (CMS) for the eight selected counties. First, we deleted Medicare beneficiaries who were considered out of scope for the focus groups: (1) beneficiaries enrolled in special endorsement cards (at CMS' request); (2) enrollees whose reason for Medicare enrollment (Original Entitlement Reason), or whose Medicare status included end stage renal disease (ESRD); (3) extremely elderly (over age 85) enrollees (because they might find it difficult to participate in a focus group); (4) drug card program enrollees who had effective card dates after July 1, 2004 (since they would not have had enough experience using the discount cards at the time of the focus groups).

The sample selection was done separately for drug card program enrollees and non-enrollees.

Selection of Enrollees

In order to recruit participants for the focus groups in each county, records had to be telematched to obtain telephone numbers for each drug card program enrollee. Following the deletion of out-of-scope records from the drug card program/T.A. enrollee file, the entire file of records was downloaded and sent out to obtain the necessary contact information. The file was returned with accompanying telephone numbers for approximately 70 percent of the records across all fifteen counties. The file was then prepared for sampling.

[43] "Counties" are referred to as cities. New York City encompassed three separate counties, so that eleven counties worth of enrollee and non-enrollee data was provided by CMS, representing eight "cities." In some areas, the converse is true, and more than one city or town may be present in a county, as in Oakland/Alameda county.

Two different populations were identified among enrollees in the fifteen counties selected for focus groups: non-T.A. card enrollees and T.A. enrollees. The variable used to determine these populations was the drug card subsidy indicator (SBSDY_IND_CD). The population of beneficiaries in each of the two strata (non-T.A. card versus T.A. enrollee) was further stratified into two substrata (disabled and not disabled). The variable for original entitlement reason (ORGNL_ENTLMT_CD) was used to determine these substrata. Some of those originally entitled due to disability have since aged and were over age 65 so focus group facilities were asked to recruit those under 65 first and then turn to the elderly disabled to complete recruitment. These four substrata within each county constituted (Non-T.A.– Aged), (T.A. – Aged), (Non-T.A. – Disabled) and (T.A. – Disabled).

Selection of Non-enrollees

We identified two different populations among the non-enrollees: beneficiaries who were probably eligible for T.A. but not enrolled ("T.A. eligible non-enrollees") and non-T.A. card non-enrollees. In order to maximize the chance of recruiters calling a beneficiary with limited income for the T.A.-eligible group, we selected zip codes within the county with a high percentage of residents with low income. Poverty levels from the 2000 Decennial Census were obtained for each zip code in the fifteen counties. The average poverty level for all zip codes in each county was calculated, and used to determine whether a given zip code in a county was above or below the average poverty level for that county. Enrollees in zip codes below the average poverty level were considered potentially eligible for focus groups with T.A. eligible non-enrollees, while enrollees in zip codes at or above the average poverty level were considered eligible for focus groups with non-T.A. non-enrollees. Final income status (i.e., eligibility for T.A.) was ascertained during focus group telephone recruiting. The file of non-enrollees in the fifteen selected counties was pre-sampled prior to sending out to telematch.

An additional consideration to facilitate recruitment for focus groups was the physical location of the focus group facility in a particular zip code in each county. Beneficiaries living closer to the facility would have less difficulty getting there. Potential participants in the focus group facility zip code were flagged to ensure the selection of at least some potential participants in each county in the focus group facility zip code. The focus group zip code variable added additional substrata to the sampling. Substrata in focus group facility zip codes were sampled with certainty (i.e., all were selected) to ensure the potential recruitment of nearby participants.

Focus Groups and Participants, by Type of Participant and City

Final strata were based on group type. Each county had three to four focus groups, spread among the six group types as shown below (Exhibit C-1). The final sampling strategy was to select 500–750 potential participants for each focus group in each city, from which 12 were to be recruited (in the expectation that 10 would actually attend).

Exhibit C-1: Number of Focus Groups and Participants, by Group Type and City

City	Non-T.A. Card Enrollees	Non-T.A. Card Non-Enrollees	T.A. Enrollees	T.A. Eligible Non-Enrollees	Disabled Non-T.A. Card Enrollees	Disabled T.A. Enrollees
New York City	22 in 2 groups		3 in 1 group			10 in 1 group
Chicago	19 in 2 groups		8 in 1 group		9 in 1 group	
Greenville	10 in 1 group	10 in 1 group	9 in 1 1 group	10 in 1 group		
Cincinnati	10 in 1 group	11 in 1 group	10 in 1 group	7 in 1 group		
Denver	7 in 1 group	7 in 1 group	10 in 1 group	1 in 1 group*		
Houston		10 in 1 group	7 in 1 group		9 in 1 group	10 in 1 group
Allentown	6 in 1 group	6 in 1 group	7 in 1 group			
Oakland	8 in 1 group	7 in 1 group	6 in 1 group	6 in 1 group		
Birmingham		7 in 1 group	6 in 1 group		8 in 1 group	8 in 1 group
Indianapolis	9 in 1 group	8 in 1 group		2 in 1 group*		
Jacksonville	10 in 1 group	3 in 1 group	10 in 1 group			
Nashville	19 in 2 groups	8 in 1 group				
Pittsburgh	9 in 1 group	3 in 1 group	5 in 1 group	4 in 1 group		
San Antonio			8 in 1 group	3 in 1 group	11 in 1 group	10 in 1 group
Wichita	22 in 2 groups	8 in 1 group				

* T.A. Eligible non-enrollees were the hardest group to recruit. In these two cities, fewer than 10 were recruited and only 1–2 actually attended; these people were interviewed separately rather than as a 'group' and the interviews were not video-taped.

The sample of 500–750 beneficiaries was first allocated to potential participants living within the focus group facility zip code if available, and then to the remainder using a systematic random sample via the SAS® Institute's PROC SURVEYSELECT.

After the sample was selected, it was determined that there were some exclusive card enrollees among the enrollee groups who were not eligible for the focus groups. In addition, recruitment difficulties were encountered in certain group and city combinations. For example, many potential focus group

participants in Oakland and Allentown refused to attend due to transportation difficulties because of the large size of this rural county and the absence of public transportation or taxis. In Allentown, where the sampling frame was very small to begin with, there were problems meeting income restrictions in the T.A. eligible non-enrollee group; recruiters had trouble finding enough people for a focus group who agreed that their incomes were below the T.A. cut-off. In all these cases, resampling occurred whenever possible to maximize participation in the focus groups. While the same SURVEYSELECT procedure featuring systematic random sampling was used for resampling, in most cases either all of the remaining eligible records were used so that in effect resampling was done with certainty, or the "sampling" was limited to a specific subgroup (for example, resampling in Oakland was limited to those potential participants who lived within the city limits.

Screening and Recruiting

Screening questions were used to verify the status of each beneficiary during recruitment, and to be sure that those we had listed as enrollees were in fact aware that they had a Medicare-Approved Drug Discount Card. Unfortunately, people sometimes were confused and answered questions incorrectly. For example, some card enrollees who acknowledged having a card during recruitment, arrived at the groups saying that they did not have a card; or they came to the groups confused and showed us all their prescription cards, none of which were Medicare-Approved Drug Discount Cards.

Recruiting scripts varied for each type of focus group. For example, the script for low-income non-enrolled T.A. eligible beneficiaries included questions about whether the individual believed himself/herself to be enrolled, whether their income was at or below the T.A. eligibility limit, and whether they had Medicaid or other private insurance coverage for prescription drugs.

Recruiters tried to recruit groups that would be mixed in terms of age, gender, and race/ethnicity for all group types. For the groups that were to consist of beneficiaries eligible for Medicare due to disability, we focused on recruiting participants who were under 65 years old because many other groups were being held entirely with seniors. Our lists extended to disabled beneficiaries over age 65 only when there were not enough under 65 who were enrolled in drug cards to fill the necessary focus groups.

Quantifying Awareness of Enrollment During Second Round Recruitment

During recruitment for the first round of focus groups, many people we reached who were listed in CMS administrative files as having Medicare-Approved Drug Discount Cards, told us that they did not have cards. During recruiting for the second round of focus groups we collected information on each recruitment call to quantify the extent of this problem. We reached many beneficiaries for each potential focus group. All those who were willing to speak with us, and to at least consider focus group participation, were asked a series of screening questions to be sure that they were eligible for the focus groups. The first screening question asked of candidates we were recruiting for enrollee focus groups, was whether the person was enrolled in a Medicare-Approved Drug Discount Card. Recruiters asked this question of beneficiaries without T.A. and also of those with the T.A. credit. We had this information from CMS databases, but wanted to recruit only people who were aware of their enrollment status. Recruiters noted responses to this question and then asked other screening questions to determine suitability for the focus groups.

Focus group candidates we spoke with, whom we knew to be enrolled based on CMS data but who answered that they were not, we have termed "unaware of enrollment." We calculated the percent "unaware of enrollment " as the number who told us they did not have a Medicare-Approved Drug Discount Card, divided by the total number of candidates reached by recruiters. The total number reached, or the denominator, was the sum of the total number recruited to attend the focus groups, the

total number who said they were unaware of enrollment, and the total number who were asked to attend but had conflicts and could not do so.

Individuals excluded from analysis were those with whom recruiters could not communicate due to language barriers or impairment, those who had passed away or were in a nursing home or hospital, those whose name/birth date did not match the records (i.e., we were not certain of their identity and eligibility), those who hung up before any screening questions could be asked, and those who refused to consider participating in a focus group and would not speak with us further. Birmingham recruiting data were also excluded from the analysis because recruiters there did not record the sample disposition information accurately enough to calculate the percentages "aware" and "unaware" with certainty.